HCFA ON-LINE: MARKET RESEARCH FOR PROVIDERS

FINAL

INVENTORY REPORT ON THE MANAGED CARE MODULE

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16. Abstract (Limit: 200 words) This report summarizes current (June 1997) communication processes between the Health Care Financing Administration (HCFA) and Medicare risk managed care plans; and describes results inferred from the interview and site visits data collection. HCFA has initiated a comprehensive communication strategy that is intended to coordinate and integrate existing communications within HCFA and develop innovative new approaches that assist all program participants to obtain and use information in the most accessible and effective manner. To that end, this study addresses two central questions: (1) What information do managed care plans need and want from HCFA?, and (2) How can this information be most effectively made available? Information on these issues were obtained from a Managed Care Advisory Panel; interviews with Medicare risk HMO staff, HCFA staff in the Central Office and Regional Offices, and Professional Review Organizations (PROs); and through review of existing HCFA communication processes and materials directed to Medicare HMOs. Results of the study are summarized in three categories: (1) information needs of Medicare HMOs, (2) information process issues, and (3) communication strategies. While risk contact HMOs stated that HCFA was forthcoming with information necessary to operate the Medicare plan successfully, their greatest concerns were about information processes. Updating material, consolidation of information, timeliness of communication, inconsistency of responses, and additional training, direction, and oversight of HCFA contractors were frequently cited communication processes that need improvement. Suggestions for communication strategies reflect that most HMOS have moved to use of electronic communication and have the ability to transfer data electronically. The consensus of HMOS and others interviewed is that HCFA is making good use of different types of communications strategies and that HMOs could obtain most information that is essential for effective operations.

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EXECUTIVE SUMMARY

Overview

Most HMOs[1] that apply for Medicare contracts have at least several years of experience managing commercial enrollments and existing operational systems in place. Even for HMOs with many years experience, however, applying for a Medicare risk contract may require substantial investments of staff time and significant costs. HCFA requirements for participation, the extent of HCFA oversight of risk contracts, and ongoing interaction between the HMO and HCFA are generally more extensive than HMOs experience in obtaining and maintaining state licensure and in serving commercial clients.

Because of these different requirements, information and communication processes between the HMO and HCFA are an important component of the Medicare risk contracting program. HMOs that are applying for Medicare risk contracts need information and guidance in understanding HCFA requirements in order to ensure that their operational systems and approach to Medicare contracting meets those requirements. Once approved and operational, risk contract HMOs have ongoing needs for information and communication with HCFA in order to operate successfully and to remain in compliance with HCFA standards.

The Health Care Financing Administration has initiated a comprehensive communication strategy that is intended to coordinate and integrate existing communication activities within HCFA and develop innovative new approaches that will assist all program participants to obtain and use information in the most accessible and effective manner. To develop a foundation of information to assist in the development of these strategies for Medicare risk contract HMOs, HCFA has funded a study to conduct Market Research for Medicare Risk HMOs. This study addresses two central questions:

1. What information do managed care plans need and want from HCFA?
2. How can this information be most effectively made available?

Information on these issues was obtained through establishing and convening a Managed Care Advisory Panel, interviews with Medicare risk HMOs, HCFA staff in the Central and Regional Offices, and PROs, and through review of existing HCFA communication processes and materials directed to Medicare HMOs. This report summarizes current communication processes and results of the data collection through interviews and site visits.

Findings

Results of the study are summarized in three categories: 1) information needs of Medicare HMOs; 2) information process issues; and 3) communication strategies.

[1] In the context of this report, the term Health Maintenance Organizations (HMOs) refers to both HMOs (federally qualified) and Competitive Medical Plans (not federally qualified).

Information Needs of Medicare risk HMOs

Discussions with HCFA Central and Regional Office staff, Medicare risk contract HMOs, PROs, and others have identified information needs of Medicare risk HMOs that are not currently being fully met by HCFA. These information items are summarized in Table 1 for HMOs in the application process and in Table 2 for operational Medicare risk contract HMOs.

Table 1: Additional Information That Would Be Most Useful During the Application Period

- Basic Information on Medicare and operational information on risk contracting, including:
  - HCFA Manuals;
  - Operational Policy Letters;
  - Transmittal Letters from Regional Office;
  - Guidelines/Regulations, such as National Marketing Guidelines, Physician Incentive Plan regulations, Standards for Review; and
  - Organizational structure of HCFA.
- Inform applicants of how long the application review process is currently taking and provide a contact person for the review.
- Inform applicants when there is a delay in the process, and the reason for the delay.
- Sources of information, including:
  - Published HCFA documents, with a brief description of contents, and instructions on how to obtain; and
  - HCFA contacts, by operational area, with e-mail addresses and telephone numbers.
- Information and data, including:
  - Medicare utilization statistics, by geographic area;
  - Information on studies conducted by, or supported by, HCFA on managed care quality, outcomes, utilization patterns, special population needs, and "best practices;"
  - Results of quality of care studies and outcomes surveys, by area of country and type of facility;
  - Quality measurement by hospital and skilled nursing facility (SNF), to assist in recruiting quality facilities for the provider networks;
  - Regulations affecting HMOs, hospitals, physicians, and other providers;
  - Listings of DRG-exempt facilities; and,
  - Physician fee schedules and DRG payment rates for hospitals.

Table 2: Information Wanted/Needed by Medicare Risk Contractor HMOs

	Upon Contract Award
Operational Information	♦ Provide a basic package of materials (interviewees suggested that this occur during the application process), including: ◊ Information on the availability of MCCOY, CompuServe, and Litton ◊ All Reporting requirements and formats ◊ The HMO/CMP Manual and associated supplementary and clarifying materials ◊ Information on the HMO required contacts with the PRO, CHDR, local carriers/fiscal intermediaries ◊ A list of all relevant HMO publications that HMOs can obtain, if desired.
	Operational Information
Carrier/Intermediary	♦ Provide, for new enrollees, utilization data/prior claims history by type of service and diagnosis ♦ Provide clearer examples of what services/procedures are covered as determined by local carriers and fiscal intermediaries, especially for controversial medical areas ♦ Provide appropriate local prevailing physician Medicare fee schedules for determining reimbursement of out-of-area care
Accretion/Deletion Process	♦ Provide a monthly report reflecting an HMO's entire enrollee membership ♦ Provide a complete and accurate listing of codes used in reports, such as Reply Listings and Exception Detail; include accurate and current institutional status code on Special Reply ♦ Label cumulative 6-month report with start and end dates and disseminate the anticipated release schedule. ♦ Enable Litton/CompuServe to provide corrected information with the list of errors--presently, plans have to look-up although Litton/CompuServe have the information. ♦ Develop industry standards/methodology for calculation of voluntary disenrollment rates. ♦ Summarize changes made in manuals given to plans on an annual basis.
Marketing	♦ Inform plans on a regular basis where marketing materials are in the review process

Table 2: Information Wanted/Needed by Medicare Risk Contractor HMOs (Cont.)

ACR Process	♦ Provide detailed information on the ACR review process, including delineation of rationale for steps and the detail behind each step ♦ Provide the methodology for how study factors are derived ♦ Provide a description of how AAPCC rates are developed and calculated ♦ Provide explicit instructions up-front on the information HMOs must submit, including the information requirements of reviewers. ♦ Provide explicit directions for how ACR information should be formatted (e.g., using LOTUS-DOS) ♦ Provide acceptable/unacceptable data sources and methodologies; ♦ Publish alternative "recommended" studies ♦ Provide guidelines for Medicare risk POS premium calculations ♦ Provide national demographic cost factors for utilization in the APR ♦ Inform plans on a regular basis where ACR submissions are in the review process.
Quality Improvement	♦ Release benchmark data (e.g., congestive heart failure and percentage of Medicare beneficiaries on ACE inhibitors) and access measures (e.g., sentinel events, such as inpatient admission that should not occur if quality ambulatory care is provided) ♦ Provide, under HEDIS 3.0, local area information, as well as overall industry information, to HMOs reporting information. ♦ Make the Standards for Review more explicit, such as types of QI studies a plan can perform ♦ Disseminate CHDR and BITS reports to all plans
Other	♦ Provide information on HCFA organizational structure and key contacts, by operational area, with e-mail addresses and telephone numbers ♦ Provide information on conferences where HCFA staff are scheduled to discuss specific issues ♦ Provide information on HCFA activities on an on-going basis ♦ Inform HMOs when HCFA staff will be out of the office, and identify a back-up person in his/her absence ♦ Provide guidelines for coordination of dual eligibles and how best to serve the special needs populations ♦ Disseminate to HMOs any information disseminated to other participants in Medicare risk program, e.g., hospitals, physicians, beneficiaries.

Information Process Issues

A number of information process issues were also identified. Process issues relate to timeliness and completeness of information provided by HCFA to Medicare risk contract HMOs and to consistency of the information provided. A summary of process issues raised in these preliminary discussions is provided in Table 3.

Communication Strategies

In addition, a number of potential ways that HCFA could communicate information to Medicare risk contract HMOs were identified. It is likely that the most effective communication strategies may be different for Medicare risk HMOs with different characteristics and that HCFA may want to develop multiple communication strategies in order to ensure that information is provided appropriately to all Medicare HMOs. Table 4 describes communication strategies that have been identified by HCFA during preliminary discussions with program participants.

Discussion

Managing information flows and designing effective communication strategies is a more complex task in a program that is rapidly changing and growing than it is when a program is stable in terms of participants and regulations and guidelines are well-established and change infrequently and only marginally. Hospitals and physicians participating in the Medicare fee-for-service program, for example, have had many years of experience and familiarity with HCFA requirements and regulations. While there have been major changes in the payment methodology over the past decade, these changes were phased in and involved extensive education campaigns. The Medicare risk contract program, on the other hand, has only been in existence for 12 years and requires much more comprehensive 'hands on' management and involvement of HCFA staff, as well as continuing refinement and development of requirements and guidelines that affect risk HMO operations.

Risk contract HMOs that were interviewed for this project generally stated that HCFA was very forthcoming with information that is necessary to operate the Medicare plan successfully. While they had specific suggestions about additional information that would improve the efficiency of the process and facilitate their operations, the greatest concerns raised were about information process. **Updating** materials to incorporate new regulations and clarify requirements was a suggestion that nearly all the HMOs made, as well as the consolidation of information which is available but spread among a number of documents issued by HCFA. Regular updating of manuals and other operating guides would ensure that HMOs had all the necessary information on any topic in one source. Similarly, **timeliness** of communication to enable Medicare HMOs to meet operational deadlines within timeframes required by HCFA was frequently raised as an issue. The HMOs also stressed that they sometimes have received **inconsistent responses** to inquiries about specific operational issues, and that it would be helpful to have HCFA develop a HCFA-wide process to ensure that all HCFA staff agree on the interpretation of specific rules and

guidelines. **Additional training, direction, and oversight of HCFA subcontractors** who provide information and communicate with HMOs, to ensure consistency and facilitate effective operations, would also allow requirements to be fulfilled more easily and reduce inefficiencies in the program. Finally, the HMOs were cognizant of the difficulties that HCFA staff may face in managing a program that is growing rapidly and made a number of suggestions that would simplify processes, reduce paperwork and interactions, and improve efficiency in the program.

Many of the HMOs' suggestions for effective communication strategies were centered around ways to improve information processes. For example, there is much information that could be placed on the HCFA Web site that, if available, would reduce the number of telephone calls between HMOs and HCFA staff or eliminate the need for HCFA staff to seek out information from other HCFA offices and subcontractors. Identifying a 'point' person in HCFA for specific issues would eliminate multiple telephone and written contacts with HCFA staff in order to obtain answers to specific questions. Finally, the suggestions for communication strategies reflect the fact that most of the interviewed HMOs have moved to use of electronic communication and have the ability to transfer data electronically. Developing a uniform consistent set of guidelines for using electronic communications and transfer of data would improve efficiency and reduce the burden on both HCFA and HMO staff involved in the Medicare risk contract program.

Table 3: Information Process Issues and Suggestions Raised By HMOs and Other Interviewees

Information Process Issue	Suggestion
Updated/Revised HCFA Materials	
	♦ Revised, updated, and indexed HMO/CMP Manual ♦ Revise applications to explicitly state requirements ♦ Establish clean copies of background materials; update as necessary; and tab
Improve Timeliness of Communications Relative to HMO Operational Requirements	
Accretion/Deletion Issues	♦ Improve timeliness and accuracy of information/data exchange between SSA, HCFA, and HCFA's authorized vendors ♦ Improve timeliness, accuracy, and exchange of data used to determine specific categories of beneficiaries ♦ Review Reply Listing and Exception Detail codes for accuracy, currency, and completeness prior to disseminating ♦ Change timing of Reply Listing to be one week sooner ♦ Disseminate DRG tape in a timely manner ♦ Communicate changes affecting Medicare claims process in a timely fashion; summarize changes in one place
Payment Issues	♦ Inform HMOs as soon as an overpayment or underpayment is discovered or suspected
Dissemination of OPLs	♦ Disseminate OPLs as HCFA CO releases them or as ROs receive them
Timeliness of Communications and Responses	♦ Allow sufficient time for HMOs to implement changes in operational procedures and information systems when issuing policies, regulations, and/or guidelines ♦ Strive to have structure in place prior to implementation of policies, regulations, and/or guidelines ♦ Provide information to HMOs, at regular intervals, as HCFA's approach is being developed ♦ Move the Annual Renewal Process to be earlier in the year
HMOs' Ability to Reach HCFA Staff	♦ Provide to HMOs a list of CO staff who have specific responsibility for specific areas and issues ♦ Establish standards for timeliness of response ♦ Increase the number of HCFA staff or streamline communication process and information transmittal mechanisms to improve timeliness of response

Table 3: Information Process Issues and Suggestions Raised By HMOs and Other Interviewees

Periodical Reviews	♦ Allow sufficient time for HMOs to implement corrective action plan, to demonstrate change, prior to re-auditing
Consistency and Coordination Between the HCFA CO, ROs, and Across ROs	
	♦ Assign to HMO a specific HCFA CO contact person to coordinate all activities and to provide clarification to questions and problems ♦ Assign specific HCFA CO staff for specific topic areas to resolve inquiries and problems related to those topic areas ♦ Identify a 'point' person to answer questions about the status of the development of new, and updating existing, policies or regulations
Simplifying Information Processes and Requirements	
Designating HMO-specific and Corporate Medicare Liaisons	♦ Allow HMOs to designate an HMO-Specific and Corporate Liaison ♦ Carbon copy designated Medicare liaison on all HCFA communications
Streamline Application Process	♦ Streamline application process to be "less paperbound" and more a real-time activity ♦ Designate appropriate "boilerplate" sections of the application
Real-Time, On-Line Medicare Beneficiary/Eligibility	♦ Strive to make Medicare beneficiary eligibility a real-time, on-line activity ♦ Allow HMOs to maintain system logs for documentation
Streamline Marketing Approval Process	♦ Institute a national "use and file" policy
Coordination with HCFA Contractors	
	♦ Provide sufficient training prior to implementation of contractors/reviewers HCFA retains to perform HCFA functions, such as the ACR review, PRO review, and on-site quality monitoring. ♦ Improve communication between the HCFA CO, the PROs, and CHDR; clarify respective roles of HCFA, PROs, CHDR, and HMOs

Table VII.1: Summary of Major Recommendations Made by Those Interviewed During This Project

COMMUNICATION STRATEGY	SUGGESTIONS FOR EXPANDED USE/CHANGES
Written Materials	Written materials should be clear and complete; changes made to updated policies, regulations, and Manuals should be explicit--"this changed in relation to this particular regulation." Materials should be organized to ensure that all written materials on a specific topic are available in one place and/or are cross-referenced with other related materials. HCFA should designate one contact point for HMOs to identify and request all written materials that are available. This could be on the HCFA Web site, with a dedicated e-mail address for orders, or there could be an 800 number specifically for ordering written materials. HCFA should move towards providing timely written responses to outstanding inquires and issues currently answered verbally. Currently, HMOs find the need to maintain extensive documentation of verbal communications. The use of e-mail would facilitate this. HCFA should create and disseminate a newsletter which could provide timely and succinct information on HCFA activities, such as initiatives, demonstrations, and pilot programs, as well as the status of regulatory developments, that may offer plans opportunities to participate or may affect their operations. HMOs are presently not well informed of the status of various HCFA activities, and not all HMOs are members of AAHP or have access to outside counsel or government affairs programs in Washington, D.C. In addition, it is easy to lose track of the initiatives over time because of sporadic communications. It was indicated that most HMOs would be willing to pay to receive a HCFA newsletter that provided them with information and understanding of HCFA initiatives and regulations.
Verbal Communication, by Telephone and In-Person	HMOs would like one person assigned at the HCFA CO to serve as their contact person for the coordination of all activities and for seeking clarification to questions. HCFA staff should update their voice mail to indicate absences, and designate an appropriate back-up person with the authority to answer questions. HCFA could set up a telephone hotline that HMOs could access to receive clarification and consistent answers to specific

Table 4: Summary of Major Recommendations Made by Those Interviewed During This Project (Cont.)

COMMUNICATION STRATEGY	SUGGESTIONS FOR EXPANDED USE/CHANGES
	regulatory or operational issues. HCFA could develop a fax on demand service to provide up-to-date information on hot topics, as AHCPR and associations have done.
E-mail and Electronic Data Transfers	Many HMOs would prefer e-mail communication to verbal communications. E-mail communication would facilitate transmittal of questions and responses that are currently being handled by telephone and would produce written documentation of the issue discussed and direction given by HCFA. HMOs would like HCFA to strive to make beneficiary eligibility a real-time, on-line activity which would improve the timeliness and accuracy of HCFA's data and enable Medicare beneficiaries to be enrolled sooner. HMOs would like to be able to show a log for documentation rather than paper copies in a file. HCFA should move towards accepting the electronic file transfer of draft marketing materials--this would permit HCFA RO staff to make changes directly in the document, return to plans in a timely manner, and produce documentation of comments and approval. HMOs support HCFA's collection of ACRs on-line, noting this was a pilot project in 1996 that will be mandatory in 1997. However, not all plans received the relevant documentation or received it after their ACRs had been submitted. Those HMOs attempting the electronic submission were unsuccessful in doing so, because of the system freezing or designated passwords not working. HMOs feel strongly that HCFA, before making it mandatory, should test the system to ensure it works and disseminate the information in a timely manner. Implement a mechanism(s) for systematically tracking where various HMO materials are in the review process. HMOs would find it most useful to be able to track: ♦ Applications/Service Area Expansions, ♦ Review of Marketing Materials, and ♦ ACR filings. HMOs could be given a password for dial-in on-line access to the tracking system for access to plan-specific information.

Table 4: Summary of Major Recommendations Made by Those Interviewed During This Project (Cont.)

COMMUNICATION STRATEGY	SUGGESTIONS FOR EXPANDED USE/CHANGES
	Modify the Grouch software to be more user-friendly, so HMOs can use the system more easily and the burden of training new staff would be decreased. Enable HMOs to download the Exception List from the MCCOY system, HCFA's on-line database system that enables HMOs to view HCFA's master file of managed care enrollees. HCFA should require that all HMOs have the ability to accept WordPerfect 6.1 files, as WordPerfect 6.1 is HCFA's standard software package for word processing.
HCFA Web site	HMOs would like to see HCFA expand the amount of information available through the HCFA Web site, and develop a process for posting the information on a more routine and timely basis (reports posted within 1 to 2 weeks of release). Increased posting of materials on the HCFA Web site would reduce HCFA's burden in copying and mailing requested materials. Materials that HMOs would like HCFA to make available through the Web site are: ♦ OPLs--HMOs would prefer that the complete catalog of OPLs be made available on the Internet; at a minimum, HMOs would like a comprehensive index of available OPLs, by subject area; ♦ General information about HCFA, including conferences where HCFA staff will be speaking and a directory of HCFA staff, by responsibility for specific areas and issues, with telephone numbers and e-mail addresses; ♦ Routine HCFA reports; and ♦ Relevant statistics and data. Specific examples of reports and data cited include: ♦ Medicare/Medicaid Sanction reports, which some plans currently receive in hard copy once a year; ♦ CHDR and BITS reports, and analysis of disenrollment patterns; ♦ OSCAR-3 reports, which contain information that HMOs find helpful and an added value in credentialing SNFs for inclusion in provider network; ♦ List of participating providers; ♦ Local fee schedules and DRGs; and ♦ Messages sent through MCCOY, as data processors are not the appropriate staff to receive these. Some HMOs indicated that they would be willing to pay a fee to access reports on-line through a password system.
CD-ROMs	CD-ROMs of HCFA Manuals should be updated to be compatible with a Windows program rather than just DOS.

Table 4: Summary of Major Recommendations Made by Those Interviewed During This Project (Cont.)

COMMUNICATION STRATEGY	SUGGESTIONS FOR EXPANDED USE/CHANGES
	HCFA should consider selecting a standard word processing program in which to publish reports and data; currently, plans are dealing with unformatted, and sometimes unusable, ASCII files. OPLs should also be made available on a CD-ROM.
Conferences and Training	Given the emergence of new Medicare risk contractors and the use of consultants HCFA should offer several courses and seminars to current and potential risk contractors: ♦ A basic course on Medicare and the risk contracting program for inexperienced organizations that are considering applying for a contract; ♦ An Application Preparation seminar explaining the various sections of the application (such as, enrollment/ disenrollment, grievances and appeals, coverage issues, and marketing materials) and addressing frequently asked questions; this presentation would allow HCFA staff to more efficiently deliver information that they now repeat to many plans during various points of the application process; and, ♦ A course for new risk contractors discussing the operational and regulatory aspects of risk contracting. HCFA could make it mandatory that potential applicants attend a seminar series prior to being able to submit an application. HCFA staff that deal directly with Medicare risk contractors would benefit from a structured training program that would enable them to understand Medicare risk contracting rules and regulations and HMO operations, including monitoring of compliance. Structured training could include direct observation of plan operations to witness the sophistication of some operational aspects. HCFA may also want to consider having HCFA reviewers attend the NCQA "Building Blocks" sessions, as well as having at least one representative from each RO attending AAHP's annual Medicare/Medicaid conference that highlights industry-wide concerns. HCFA CO forums with plans and advocacy groups on new regulations or new interpretations of regulations, such as HEDIS/CAHPS, Enrollment and Payment, and Physician Incentive Plan regulations, are very helpful to HMOs. The seminars should offered in a timely manner to consider the operational impacts on HMOs. HMOs would like HCFA to continue offering such seminars, and, to the extent possible, expand their use. HMOs would like ROs to conduct meetings on a regular basis, such as quarterly, that bring together Medicare risk contractors to discuss issues affecting all HMOs and to conduct question and answer sessions. These sessions would allow RO staff to be aware of issues of concern to HMOs, as well as HMOs to be aware of the RO perspective.

I. OVERVIEW

Objectives of HCFA On-Line: Market Research for Providers and Other Partners

HCFA On-Line is being developed to meet the information needs of Medicare beneficiaries, providers, managed care plans, and other partners who interact with the Medicare program. This comprehensive communication strategy is intended to coordinate and integrate existing communication activities of Health Care Financing Administration (HCFA) and to develop innovative new approaches that will assist all program participants to obtain and use information in the most accessible and effective manner. Developing such a far-reaching and innovative strategy to meet the goals and objectives of the Agency requires that there be better data and information on providers' current understanding of the program and information needs of physicians, hospitals, and managed care plans; special communication strategies that address differences among subgroups of providers in their ability to access and use information; and mechanisms and approaches that will efficiently and effectively reach these groups.

This project, "HCFA On-Line: Market Research for Providers and Other Partners," will provide a foundation of information to assist in the development of these strategies for managed care plans, physicians, and hospitals that serve Medicare beneficiaries. The study addresses two central questions:

1. What information do managed care plans and providers need and want from HCFA?
2. How can this information be most effectively made available?

The tasks to be undertaken to address these questions will produce a comprehensive set of data and analytic findings that will provide HCFA with the information needed to design the HCFA On-Line strategy that will be most effective in reaching Medicare managed care plans and providers with different characteristics and sets of issues.

The broad goals of HCFA On-Line go beyond simply providing easily accessible information on Medicare benefits and coverage. Instead, it is intended that HCFA become a source of information to Medicare beneficiaries, providers, and other partners on a variety of issues that must be addressed in order to improve and maintain health status and quality of life--including health promotion and prevention approaches, treatment options for medical conditions, and other topics that are of concern and importance to an aging population and to those who are eligible for Medicare due to disabilities. In addition, the project focuses on innovative communication strategies, development of special materials and dissemination modes, and other approaches to ensure that effective information and strategies for outreach are identified for subgroups of providers and managed care plans (e.g., rural hospitals, physicians serving the dually eligible).

The Market Research for Beneficiaries and the Market Research for Providers and Other Partners projects include components that are interrelated and that draw on some of the same sources of information and materials. For example, under the Market Research for

Beneficiaries project, the Barents Group team is interviewing managed care companies and large private employers to identify innovative communication strategies that are being used to reach beneficiaries. Some of these same communication strategies may also be potentially useful for reaching providers and managed care plans. Similarly, the findings on the information needs of Medicare beneficiaries will be relevant for identifying some of the information needs of providers and managed care plans, since these entities need information to address the questions of their patients and enrollees and to assist them in using the Medicare program effectively.

Approach and Methods

The initial three groups selected by HCFA to be examined for the providers project are managed care organizations contracting with HCFA, hospitals, and physicians. Additional provider or partner groups may be added to the project in the future. Each provider/partner module is being conducted separately, with separate reports to be prepared on the findings for each module. At the end of the project, a summary report will be prepared in order to synthesize general communication issues that have been identified across all the groups.

The approach that is being taken to collect information on information needs and most effective communication strategies is similar for each module:

- An advisory panel is assembled for each module, consisting of representatives from the relevant industry organizations, operational and management staff from representative partners/providers, and representatives from HCFA regional offices. These panels have met early in the project and have provided detailed input on the direction of the project and issues that should be examined.
- An inventory is conducted to identify issues and obtain insights into the information needs and most effective communication strategies for each of the modules. The subtasks completed for the inventories include:
  - Meetings with appropriate HCFA staff in the Central Office are arranged to gather information on current interactions between HCFA offices and each partner/provider group. In addition, any written regulations and policies and procedures that are intended to provide guidance and operational information to the partner/provider are obtained and reviewed in order to develop a conceptual model of existing information flows and communication strategies.
  - A literature search and review is conducted to identify issues that have been raised within the industry about interactions with HCFA and information desired by the industry from HCFA.
  - Unstructured interviews with industry association representatives, HCFA Regional Offices, Peer Review Organizations (PROs), and individual partners/providers are conducted to obtain background and guidance on current information flows, information needs, and communication strategies.

- ◊ Site visits to three cities are conducted to obtain in-depth knowledge of current operations and interactions with HCFA by specific partners/providers. In addition, these site visits include meetings with HCFA Regional Office staff, fiscal intermediaries and carriers, and PROs to obtain information on current information processes and communication strategies.
- ◊ An inventory report summarizing the findings from these activities will be prepared and submitted to HCFA upon completion of the site visits.

- ♦ Focus groups are being conducted to obtain additional insights into information needs and communication strategies from a broader set of participants for each of the partner/provider modules. A separate report on the results of the focus group task will be prepared and submitted to HCFA.
- ♦ Additional data collection, after completion of the inventory and the focus group tasks, will be conducted in order to obtain information from a wider variety of organizations and providers. A survey will be conducted to obtain data from physicians. For managed care plans, a Federal Register Notice will be published summarizing the objectives of the Managed Care Module and the findings from the Inventory Report. HMOs and other interested organizations and entities will be asked to comment and provide additional input.

The Managed Care Module

This report summarizes the findings from the inventory of information needs and communication strategies for Medicare risk contract Health Maintenance Organizations (HMOs)[2].

The structure for the Managed Care Module inventory is focused on the current interactions of HCFA and HMOs, both current risk contractors and those that are interested in and may eventually become Medicare risk contractors. We explored information needs and effective communication strategies for three groups of HMOs[3]:

1. HMOs that are not Medicare risk contractors, but are interested in obtaining information about Medicare risk contracting in order to decide whether to enter the program;
2. HMOs that have recently completed the application process and are now in the first months of enrolling and serving Medicare beneficiaries; and,
3. HMOs that have been Medicare risk contractors for several years and have experienced ongoing communications and monitoring for that period.

[2] In the context of this report, the term Health Maintenance Organizations (HMOs) refers to both HMOs (federally qualified) and Competitive Medical Plans (not federally qualified).

[3] The project intended to also obtain data from HMOs that had participated in Medicare risk contracts and subsequently had withdrawn. However, during the project it was determined that there were only a very few HMOs in this group and that, for the most part, these HMOs would be unlikely to provide information that would be relevant to HCFA and to other HMOs. As a result, this fourth group was not included in the study.

We also recognized that HCFA information and interactions with HMOs come from several different areas within HCFA and that it was important to examine the information and communication strategies used by each of these components of HCFA. Therefore, we explored the information provided and communication strategies involving:

1. The Office of Managed Care, which has primary responsibility for information on Medicare risk contracting, and is responsible for the application and approval process for new risk HMOs;
2. HCFA Regional Offices that have responsibility for oversight and approval of day-to-day aspects of operations of Medicare risk contractors, including marketing plans; and
3. PROs that are taking on increasing responsibility for oversight of quality of care in risk contract HMOs.

Prior to beginning the inventory for the Managed Care Module, a Managed Care Advisory Panel meeting was held on December 12, 1996. The Advisory Panel included representatives from the American Association of Health Plans, three Medicare risk HMOs, and a HCFA Regional Office staff person with oversight responsibility for Medicare risk HMOs. The objective of the Advisory Panel meeting was to identify issues of information and communication that are concerns of Medicare risk contractors and to obtain guidance for the selection of sites for in-depth meetings with HMOs, design of the focus group strategy, and the structure of the survey component of the Managed Care Module. A summary of the information provided to the project by the Advisory Panel is contained in Appendix A to this report.

An inventory of information needs and communication strategies relevant for Medicare risk contract HMOs was then conducted. The results of this inventory provide guidance for the design of the focus group and survey components of the Managed Care Module. There are three components of the Managed Care Inventory:

- A review of HCFA and industry publications to identify current communications and "hot topics," the information needs of Medicare HMOs, and communication strategies that are most effective for HCFA to use in working with Medicare risk contractors;
- Interviews with and site visits to HCFA Central and Regional Offices that are responsible for providing information to Medicare risk contractors to document the current information flow and to identify potential gaps and problems in communication from HCFA's perspective; and
- Site visits to and interviews with HMOs that have considered Medicare risk contracting, those that have recently applied and been approved for a Medicare risk contract, and those that have several years experience with Medicare contracting, as well as interviews with industry association personnel that have assisted members in working with and understanding HCFA requirements and rules, PROs that work with Medicare HMOs, and consultants. In addition, interviews were conducted with Medicare beneficiary advocacy groups in order to identify information needs of

Medicare HMOs that these groups believed would help to improve the effectiveness of the program.

Review of Relevant Background Materials

This review of materials for the Managed Care Module had several components:

- Materials that are provided to HMOs that contact HCFA to obtain information on Medicare risk contracting, the application form and instructions, reporting requirements, and examples of information memoranda that are provided in response to specific types of requests for information were reviewed;
- The major "Handbooks" to Medicare risk contracting that may be used by HMOs and consultants who are preparing Medicare risk contract applications and by HMOs who are in the early stages of operating a Medicare risk program were obtained and reviewed; and
- A search of the literature was conducted to identify articles, reports, and research on HMO information needs and effective communication strategies related to Medicare risk contracting. However, virtually no relevant literature was identified. Appendix B summarizes the search that was conducted.

The results of this review were then used to develop a model of HCFA-HMO information transactions and communication strategies to design the site visit approach, and to develop interview guides.

Interviews in the Washington/Baltimore Area and by Telephone

Interviews were conducted with a number of organizations and individuals in the Washington, DC area to obtain background information and guidance to structure the site visits to specific HMOs and HCFA Regional Offices. The principal categories of organizations that were interviewed include:

- HCFA staff with responsibility for one or more aspects of Medicare risk contract approval, oversight, and monitoring. An initial overview meeting with staff from the Office of Managed Care was held to gain a better understanding of the process through which HMOs inquire, apply, and operate risk contracts and the role of different components of HCFA in facilitating these processes. Then, more in-depth meetings were held with HCFA staff from OMC and other components of HCFA that have a role in oversight of HMO risk contractors in order to "walk through" the information transactions and to discuss examples of problems that may have been encountered, and any new communication modes and strategies for meeting information needs that have either been recently introduced, or are being considered;
- A meeting was held with the staff of the American Association of Health Plans (AAHP) office that are responsible for working with plan members to understand the Medicare risk contract program and to interpret Medicare provided information for members;

- Some consulting firms that assist HMOs to apply for Medicare risk contracts and to assist them in assessing and re-structuring their operations to meet all Medicare risk contract requirements were interviewed. These organizations have worked with many HMOs and are often the primary contact point between the HMOs and HCFA in obtaining information and interpreting that information to develop operational guidelines;
- Telephone interviews were conducted with staff from two Regional Offices in order to document the responsibilities and interactions of Regional Office staff with HMOs in different stages of Medicare risk contracting and to obtain insight into the information needs of HMOs and the differences among Regional Offices in their approach to communication with HMOs; and
- Telephone interviews were conducted with HMOs at different stages of Medicare risk contracting: not presently a Medicare risk contractor; just beginning operating a Medicare risk contract program; and operating a risk contract program for several years.

Site Visits

Following the Advisory Panel meeting, site visit criteria were developed that included:

- Site must have at least three Medicare HMOs, one of which must been operational for at least three years and one of which must have been operational for a year or less;
- Site must have a HCFA Regional Office; and
- Site must have a PRO.

Sites that met these criteria were then categorized by low, medium, and high Medicare HMO enrollment market penetration. HCFA then selected three areas in which site visits would be conducted.

Site visits were conducted to three areas:

- Philadelphia, PA
  January 13-14, 1997
- San Francisco and Los Angeles, CA
  January 20-22, 1997
- Newark, NJ/New York City area
  January 30-31, 1997

Appendix C of this report contains the Site Visit Protocol and the Interview Guides that were used in these site visits.

Total Interviews and Site Visits

Between the telephone interviews and the site visits conducted, information was collected on information needs and communication strategies for the following categories of organizations:

Table I-1: Interviews and Site Visits

Organization	Number
Medicare HMOs	17
HCFA Regional Offices	5
PROs	2
Industry Associations	4
Consulting Firms	2

In addition, meetings were held with HCFA Central Office staff and a large amount of material was gathered and reviewed from HCFA and from the HMO and consulting industries.

Structure of this Report

This Inventory Report on the Managed Care Module of HCFA On-Line: Market Research for Providers summarizes the finding obtained from the Advisory Panel meeting, review of HCFA and other materials, interviews and site visits conducted between November and January 1997. It provides substantial background and information on current information interactions between HCFA and Medicare HMOs, identifies information needs of Medicare HMOs and current information process, as well as the communication strategies that HMOs identified as most effective. Results summarized in this report provide background for the Managed Care Focus Groups and for determining the most effective survey strategy to obtain additional insight from larger numbers of Medicare HMOs in the next phases of the Managed Care Module.

In the next section of the report, background and history of the Medicare risk contract program is provided to create a context for the project. Then, in the third and fourth sections of the report, the current process and information interactions between HCFA and Medicare HMOs are described. Findings are discussed in the fourth through sixth sections and cover information needs, information process, and effective communication strategies identified by Medicare HMOs during interviews and site visits. The final section of this report summarizes and discusses the key issues and information collected during the inventory component of this project.

II. A BRIEF HISTORY OF THE MEDICARE RISK CONTRACT PROGRAM

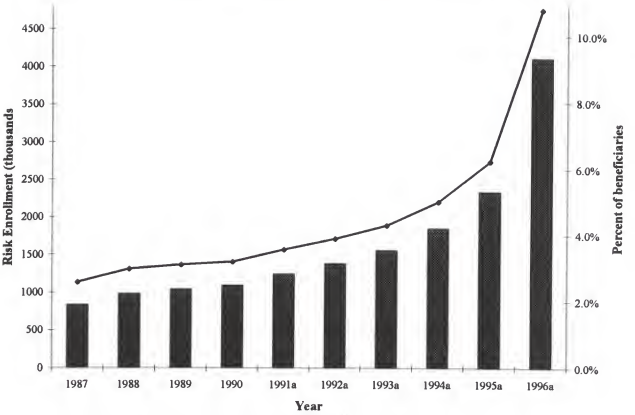
Since early 1985, Medicare beneficiaries have been allowed to choose between joining a Medicare risk contract HMO and remaining in traditional fee-for-service Medicare, in areas where a Medicare risk HMO is available. HMOs that voluntarily participate in Medicare receive a capitation payment for each Medicare beneficiary that enrolls. This payment is set at a level that is projected to cover the expected costs of providing all Medicare benefits in the county of residence of the enrollee. The methodology used to determine the monthly payment for enrolled Medicare beneficiaries is based on national average Medicare costs in the fee-for-service sector, adjusted for the historic costs of medical care in the enrollee's country of residence and for certain characteristics of enrollees that are expected to affect their use of medical services (i.e., age, sex, disability status, Medicaid status, and institutional status). In order that Medicare obtain cost savings from the managed care program, HMOs receive only 95 percent of the projected fee-for service costs.

Enrollment of Medicare beneficiaries in risk contract HMOs has grown steadily since the program was implemented in 1985, and has been increasing more rapidly since 1994 (Figure 1). In 1987, 836,713 thousand Medicare beneficiaries (2.6 percent) were enrolled in risk HMOs; by December 1996, over 10 percent of all Medicare beneficiaries were enrolled in HMOs. This enrollment, however, is concentrated in a few states. Approximately 45.6 percent of Medicare HMO enrollees in 1996 resided in five states: Arizona, California, Colorado, Nevada, and Oregon. The geographic distribution of risk contract enrollment is becoming more representative over time, as more HMOs across the country offer Medicare products.

The relatively rapid growth in Medicare risk enrollment that has occurred since 1994 may be attributable to several factors. More HMOs have entered the program and so more options are available to Medicare beneficiaries in more parts of the country. In addition, managed care is becoming a generally better known phenomena, as private sector managed care has expanded and the majority of private insurance plans now involve some type of managed care.

One reason that enrollment may have increased is that the premiums charged by Medicare HMOs to cover supplemental benefits and reduced cost-sharing have also been declining, making the HMO option more attractive to Medicare beneficiaries. Medicare HMOs must calculate their costs (including an acceptable level of profit) of providing Medicare benefits to enrollees. If these projected costs are less than the payment that they will receive from HCFA, they must either return the savings to Medicare or offer the savings to their Medicare enrollees in the form of reduced cost-sharing and supplemental benefits. Supplemental benefits offered by HMOs to their Medicare enrollees have been increasing

Figure II.1: Growth in Medicare Beneficiary Enrollment in Managed Care, 1987-1996

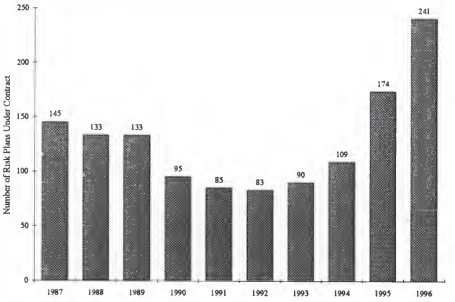


Note: 1987-1990 HCFA data reflect enrollment as of January of each year.
a: Denotes HCFA data reflecting enrollment as of December of each year.
Source: HCFA, Office of Managed Care, "Medicare Managed Care Program Update, 1995," and "Monthly Report of Medicare Prepaid Health Plans," December 1991 through December 1996.

in recent years. Between 1995 and 1996, the proportion of Medicare HMOs that offered reduced cost-sharing and supplemental benefits to their enrollees for a zero premium increased from 50 percent to 64 percent, suggesting that competition among HMOs for Medicare enrollees is resulting in reduced premiums.

A major reason for the more rapid growth of Medicare enrollments in risk contract HMOs has been the recent upsurge in the number of HMOs participating in the program. However, the participation of HMOs in Medicare risk contracting has varied over the 12 years that the program has been in existence. In 1987, 145 HMOs had risk contracts with Medicare; this number gradually declined over the next several years and, by 1992, only 83 HMOs were participating in the risk contract program (Figure 2). Since 1992, the number of HMOs with risk contracts has grown, particularly in the 1994 to 1996 period. As of December 1996, 241 HMOs were offering Medicare products to beneficiaries under the risk contract program.

Figure II.2: Number of Medicare Risk Plans, 1987-1996



Source: HCFA, Office of Managed Care, "Medicare Managed Care Program Update, 1995," and "Monthly Report of Medicare Prepaid Health Plans," December 1995 and December 1996.

Despite the increase in the number of HMOs participating in Medicare, a small number of plans in a few states still account for a significant proportion of total Medicare risk contract enrollments although this concentration is declining. In 1995, the largest eight plans accounted for 46 percent of total enrollment. By 1996, with the entry of over 50 new plans into the market, the largest eight plans accounted for only 34 percent of total enrollment. Thus, the entry of new plans located in a broader geographic area appears to be resulting in more HMO options available to Medicare beneficiaries and the most rapid

growth in enrollment has been in areas where new plans are operating rather than in those areas where large Medicare HMOs have been operating for longer time periods.

The increase in the number of HMOs participating in the Medicare risk contract program and the recent surge in the number of enrollments has required significant additional effort for HCFA staff to manage and provide appropriate guidance to these new program participants. In 1992, only 83 HMOs participated n the program. Between 1993 and 1996, 158 additional HMOs submitted applications and were reviewed and approved to serve the Medicare population. Thus, HCFA was monitoring over three times as many HMOs in 1996 as in 1992.

Current projections of Medicare HMO enrollment suggest that by 2002 as many as 25 percent of Medicare beneficiaries will be enrolled in Medicare HMOs This growth in enrollment will almost certainly be accompanied by similar growth in the number of HMOs in the program. To ensure that HMOs meet all HCFA requirements and offer good service to Medicare beneficiaries, clear and useful information from HCFA will be critical. At the same time, the increasing demands on HCFA staff responsible for approving and monitoring HMOs that participate in the program make it even more important that effective strategies for communication be developed to provide all the necessary information in a timely manner.

III. FRAMEWORK FOR THE INVENTORY

Overview

To apply for and be approved to operate as a Medicare risk contractor, HMOs must be licensed in their state of operations and have at least 5,000 commercial members. Most HMOs that have applied for Medicare contracts have at least several years of experience managing commercial enrollments and existing operational systems in place. Even for HMOs with many years experience, however, applying for a Medicare risk contract may require substantial investments of staff time and significant costs . HCFA requirements for participation, the extent of HCFA oversight of risk contracts, and ongoing interaction between the HMO and HCFA are generally much greater than HMOs experience in obtaining and maintaining state licensure and in serving commercial clients.

Because of these different requirements, information and communication processes between the HMO and HCFA are an important component of the Medicare risk contracting program. HMOs that are applying for Medicare risk contracts need information and guidance in understanding HCFA requirements in order to ensure that their operational systems and approach to Medicare contracting meets those requirements. Once approved and operational, risk contract HMOs have ongoing needs for information and communication with HCFA in order to operate successfully and to remain in compliance with HCFA standards.

Information from HCFA comes from a number of different sources, including:

- The HCFA Central Office in Baltimore;
- The HCFA Regional Offices;
- Peer Review Organizations; and
- Other HCFA contractors, who are responsible for specific operational functions.

HMOs are responsible for obtaining, understanding, integrating, and operationalizing information received from all these sources and for seeking clarification of specific aspects of the risk contract process, when necessary. Table III-1 summarizes the major areas of responsibility for providing information and ongoing communication with risk contract HMOs for each of these HCFA information sources.

In this section, the processes of HMO and HCFA interactions are described for the application period and for ongoing operations of a Medicare risk contract. The framework for these interactions provides the basis for developing interview and site visit protocols used to elicit information from Medicare risk HMOs and HCFA staff on information needs of HMOs, information exchange, and communication processes.

Table III-1: HCFA Information Sources

SOURCE	INFORMATION RESPONSIBILITY
HCFA Central Office	Legal, regulatory, and financial issues. Payment Process Accretion/Deletion Process Application Site Visit
HCFA Regional Offices	Operational requirements/review Review marketing materials and other beneficiary communications Monitoring site visits and follow-up Retroactive enrollments
Peer Review Organizations	Review and studies of quality Investigation and follow-up of beneficiary complaints and non-coverage notices
Other HCFA Contractors	
♦ Intermediaries and Carriers	Coverage decisions (e.g., local carriers medical review policies) Payment rates for out-of-area services
♦ ACR Review Contractor	Completeness review of ACR submissions (HCFA completes the ACR review for all new plans entering the Medicare risk program)
♦ Center for Health Dispute Resolution	Reconsiderations

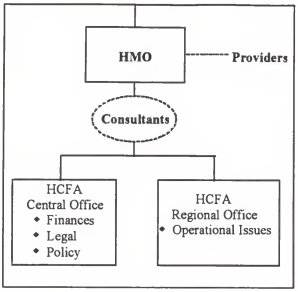
The Application Process

Undertaking a Medicare risk contract requires that HMOs address a number of issues that are different from their commercial enrollment and service delivery processes. The differences between the experience of HMOs in operating a commercial HMO based on employer contracts and the requirements for a Medicare risk contract makes it likely that an HMO beginning the Medicare risk application process will obtain assistance from some source that has prior experience in Medicare risk contracting. For HMOs that are part of a national chain that has other Medicare risk contracts, that experience may come from a group in the corporate office of the chain. Other HMOs may hire an individual with prior Medicare risk contract experience to lead the application and implementation processes. Many HMOs hire consulting firms with Medicare risk contract experience to guide them through the process of applying and to assist in preparation of the application.

Communication between the HMO (and its contractor) in the application process and HCFA is depicted in Figure III-1. Information to clarify requirements may be requested from the HCFA Central Office or the HCFA Regional Office, depending on the specific type of requirement and assignment of responsibilities between the HCFA Central Office

and the Regional Offices. Establishing the correct lines of communication early in the process is essential to the HMO's ability to develop a successful Medicare application.

Figure III-1: Communication Flows During Application Process



Ongoing Operations

Once HCFA has approved the application submitted by the HMO, implementation and ongoing operations of the Medicare risk plan requires continuing interaction and information exchange between the HMO and HCFA. Both the Central Office and the Regional Offices have specific responsibilities with respect to communication with the HMO. HCFA delegates some of its responsibilities for quality assurance to Peer Review Organizations that work directly with the Medicare HMOs. HCFA also uses contractors to handle some functions; for example, HCFA contracts for Adjusted Community Rating (ACR) review services and this contractor deals directly with each HMO to obtain information and clarify submissions before completing a preliminary review and forwarding the ACR submissions to HCFA for approval. In addition, HMOs require information from HCFA intermediaries and carriers to coordinate coverage decisions and to pay out-of-area providers. HMOs also must work with the Center for Health Dispute Resolution (CHDR) on reconsideration.

The operational Medicare risk HMO maintains close communication with HCFA on an ongoing or periodic basis for the following functions and requirements:

- Marketing Materials and Plans. The Medicare HMO must obtain advance approval from the HCFA Regional Office of any materials that will be used to market to, or communicate with, Medicare beneficiaries.

- Enrollment/Disenrollment. The Medicare HMO submits monthly lists of new enrollees and disenrolled members to HCFA's Central Office data system either directly or through an intermediary (e.g., CompuServe) which HCFA uses to determine payment. Discrepancies require resolution that involves interaction between the HMO and HCFA.

- Quality Assurance. The Medicare HMO must provide information and may participate in quality assurance and quality improvement initiatives that are developed by HCFA's Central Office, both OMC and Health Standards and Quality Bureau (HSQB), and the designated PRO in their area. The PRO also follows up with HMO member complaints, grievances, and appeals, working with the HMO staff. Regional Offices can also request corrective action plans for quality related issues and monitor compliance.

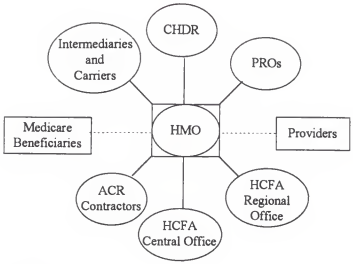
- Financial. Annually, the Medicare HMO must prepare financial projections and analyses to support the benefit package and premiums that will be offered to Medicare beneficiaries. HCFA currently uses a contractor to initiate the ACR review process and to work with the HMOs to clarify components of the HMO's submission. The final review and approval process is conducted by HCFA's Central Office and may involve further requests for information and clarification.

- New Regulations/Changes in Regulations. HCFA's Central Office has responsibility for developing new regulations based on legislation and for making changes in existing regulations. In some cases, Medicare HMOs are asked to participate in the development of new regulations and to provide data, information, or comments on these regulations-in-development. Once the regulation has been finalized, it is published in the Federal Register, which is printed by the Government Printing Office and widely disseminated. Clarification and elaboration of the intent and operational implications of the new regulation may be provided by the Central Office or by the Regional Offices.

- Ongoing Monitoring and Reporting. Medicare HMOs are responsible for regular reporting and site visits are conducted periodically to each HMO by staff from the Central Office and Regional Office. The site visits are comprehensive in nature and normally include review of every operational area of the Medicare HMO. Following the site visit, the HMO is notified of any areas in which deficiencies were identified and are asked to prepare a corrective action plan. If serious deficiencies or problems are identified, HCFA could suspend the HMO from new enrollments until the problem has been corrected, issue an intermediate sanction (an administration action of less than termination of contract), or terminate the HMO from the program.

Figure III-2 depicts the ongoing process of communication and other gaps, once the risk contract HMO becomes operational. The HCFA Central Office is responsible for providing direction to other entities with which the HMOs communicate, and shares responsibility with the HCFA Regional Offices for communicating with PROs, Intermediaries, and Carriers.

Figure III.2:



Legend
ACR Contractors: Adjusted Community Rate Contractors
CHDR: Center for Health Dispute Resolution
HMO: Health Maintenance Organization or Competitive Medical Plan
PROs: Peer Review Organizations

IV. DESCRIPTION OF HCFA PROCESSES AND COMMUNICATION METHODS

Overview

The Medicare risk contract program has operated since 1985. Consequently, HCFA has developed standard communication processes and written materials that are intended to provide information to HMOs during the application process and to support the Medicare risk HMO once it becomes operational. This section reviews those processes and materials to illustrate current communications and information provided to Medicare risk HMOs.

The Application Process

The application process formally begins when an HMO contacts HCFA to request an application package, which includes directions for submitting an application, requirements to be addressed in the application, and background information and supporting materials. Once HCFA is aware that an HMO is developing an application, the Central Office works with the HMO on legal, regulatory, and financial issues and the Regional Office works with the plan on operational and marketing issues. The application materials provide direction and information on requirements, while the Central Office and Regional Offices are responsible for providing additional information and clarification to the HMO during the application process. Since there is no HCFA deadline for submitting an application, once it is initiated, the time that elapses between request for an application package and submission of the application may vary from a few months to a year or more. The timing may depend on how knowledgeable about Medicare risk contracting the HMO and its consultants (if any) are and on the communication flow between the HMO and HCFA staff assigned to work with them.

HMOs that are part of a national chain that already has other Medicare risk contracts may be able to move more quickly to complete an application. In some cases, the HCFA Central Office has assigned a Plan Manager to the national chain who oversees all of their new applications, as well as providing oversight to operational HMOs associated with the chain. However, since there are differences among the Regional Offices in process and interpretation of some requirements, there still may be a need for considerable interaction and communication with the Regional Office staff to ensure that all requirements are being incorporated into the application.

HMOs that are not part of a chain that has existing Medicare risk contracts may hire actuarial and/or application preparation consultants, or may carry out the application process with internal staff. Those that hire consultants may be able to prepare the application more quickly because of the knowledge and prior HCFA contacts of the consultants, if the consultant has recent and comprehensive experience in this area. HMOs that decide to pursue an application using internal staff may need a longer time period to prepare the application, since establishing communication links with HCFA and

understanding and interpreting the written application materials and background materials may take a longer time.

Once the application has been submitted, it is reviewed by HCFA for completeness. After initial review of the application, HCFA informs the HMO in writing of any areas of concern. The HMO is given 60 days to respond to the issues raised by HCFA and submit supplementary documentation. After receiving this additional information from the HMO, a HCFA review team then completes an in-depth analysis of the HMO's financial submissions, operational readiness, and the HMO's ACR submission. A site visit is then conducted to the HMO to verify the information submitted and to assess the HMO's readiness to undertake a risk contract. The Central Office leads this site visit. If additional issues are raised by the site visit, the HMO is informed and HCFA sends a report to the HMO identifying outstanding issues for resolution. The HMO is expected to respond to HCFA within 60 days or the application can be denied. Assuming the HMO is able to successfully address all outstanding issues, each HCFA review team member prepares a "Desk Report" on the portion of the application he/she reviewed. These reports are then synthesized into a "Recommendation Report" and sent to key managers and the OMC Director for final approval. If the HMO does not respond within 60 days or if deficiencies are identified that are expected to require more than 60 days to resolve, the application may be denied. Applicants who receive denials are permitted to request a conference with HCFA to discuss the identified issues and may, in some cases, be offered the opportunity to address these issues over a longer time period.

Information that is provided to HMOs by HCFA during the application process is shown in Table IV-1.

Ongoing Medicare Risk Contract Operations

Once the HMO's application has been approved, the HMO then moves into the implementation phase of the risk contract. A copy of the HMO/CMP Manual and other manuals with more detailed direction for operating the risk contract according to HCFA guidelines is sent to the HMO to assist with implementation details. (See Figure 3 for the Table of Contents of the HMO/CMP Manual.) The HMO/CMP Manual has not been updated for several years and is missing some information that would clarify guidelines and provide direction for HMOs in areas where new regulations have been issued in the past few years. HCFA also provides, with the Manual, copies of Manual Transmittals that have been issued that modify the Manual.

Prior to implementation, marketing materials are submitted to the Regional Office for approval; marketing to Medicare beneficiaries begins; and enrollment of Medicare beneficiaries into the plan is initiated. The HMO must also implement its management information system components that will submit enrollment and disenrollment data to HCFA and finalize other operational systems prior to beginning to serve Medicare enrollees.

Table IV-1: HCFA Communications with HMOs During Application Process

HCFA Publications	Publication Summary
1. Medicare Contract Application: Competitive Medical Plan 2. Reference materials	1. Describes eligibility criteria; details technical and general preparation instructions; includes forms to be completed; provides list of RO contacts. 2. Excerpts from HMO Act, Federal Register, SSA Section 1876, 42 CFR Part 417, and the Medicare HMO/CMP Manual; Financial Guidelines; Insolvency Protection for Members; Highlights of Medicare Claims Reconsideration Appeals Process; HMO National Data Reporting Requirements (NAIC)
HCFA Written Materials	1. Application packet and background materials 2. Letter indicating results of completeness review of application and request for supplementary information. 3. Letter to schedule site visit, with instructions for the HMO to help prepare for site visit. 4. Letter indicating deficiencies identified during site visits. 5. Other written communications to clarify and respond to HMO's questions. 6. Approval/disapproval letter.
Verbal Communications	1. Central Office response to HMO telephone or other inquiries. 2. Regional Office response to HMO telephone or other inquiries. 3. Site visit to HMO to verify information and obtain additional detail and understanding of HMO operations.

Figure 3. Health Maintenance Organization/Competitive Medical Plan Manual Table of Contents

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Ongoing communication between the HMO and HCFA, once the implementation has occurred, include the following:

- All changes in marketing materials and new marketing materials must be submitted to the Regional Office for review and approval before they can be used. For national chains that develop marketing materials to be used by HMOs in different HCFA regions, one Regional Office can be designated to coordinate the review and approval of the materials to be used across regions.
- On a monthly basis, the HMO submits its new enrollees and disenrollees to HCFA. Resolution of problems in identifying or verifying eligibility of new enrollees are resolved on a continuous basis by communication between the HMO and HCFA. Every six months, HCFA provides a comprehensive list to the HMO of its enrollees and disenrollees according to the HCFA database. Resolution of differences between the HMO and HCFA on this comprehensive list is then initiated by the HMO. Since a fairly high number of problems occur in the accretion/deletion process and payment to the HMO depends on the accuracy of these data, considerable communication between HCFA and many plans occurs around these issues.
- On an annual basis, the HMO develops its financial projections, ACR, and benefit and premium offering for the next year. The ACR review process involves communication between the HMO and the contractor who conducts the preliminary review of the ACR, and between the HMO and HCFA to finalize the ACR approval. (A contractor was used for the first time in 1996 to do all initial reviews.)
- Periodically, the HCFA Regional Office conducts site visits to each Medicare risk HMO to examine documentation of operational components of the HMO and to review internal processes to assess compliance with all HCFA requirements. As part of this site visit, the Central Office also reviews legal and financial documents. The HMO is provided in advance a letter that outlines the documentation that will be reviewed during the site visit and HMO staff with whom HCFA expects to meet. When inadequate documentation is available or other problems are identified by the Regional Office during the site visit, the HMO receives a written report detailing these deficiencies and is expected to respond with a corrective action plan that is approved or disapproved by HCFA. Subsequent site visits document the implementation of the corrective actions.
- When new interpretations of HCFA regulations/policies are issued or new regulations/policies are implemented, HCFA communicates these changes to the HMO and the dates by which the HMO must implement these changes. (New regulations are also published in the Federal Register.) Questions and requests for clarification are initiated by the HMO to the Regional Office or the Central Office Plan Managers following receipt of the notice of changes. In addition, during the development of new regulations/policies, HCFA sometimes actively seeks input and review of interim versions of the regulation/policy from the Medicare risk HMOs. Two recent examples are the development of National Marketing Materials Review Guidelines (clarification of policy) and the Physician Incentive Payment regulations (regulations), both of which

were in development during 1996 and before. For example, the Physician Incentive Payment regulations were issued in the Federal Register in final form on March 27, 1996; an additional notice was published in the Federal Register on September 3, 1996; and a corrected final notice appeared in the Federal Register on December 31, 1996 for an effective date of implementation of January 1, 1997.

- The HMO works with the local Peer Review Organization (PRO) to implement studies related to quality of care and to resolve potential quality of care issues forwarded by the Center for Health Dispute Resolution (CHDR), after a reconsideration decision has been rendered, for further review.
- The HMO submits upheld or partially denied beneficiary appeals to the CHDR for reconsideration and determination.
- HMOs require information on local coverage decisions from the HCFA carrier and intermediary, as well as other entities for identifying beneficiaries in specific categories (such as, end-stage renal disease). They also require information on established HCFA payment rates from carriers and intermediaries in other areas of the country, in order to establish appropriate reimbursement for services provided to Medicare members out-of-area. This information may be obtained directly from the carrier or intermediary or may be requested from the Regional Office or Central Office Plan Managers.

A list of the major written materials provided by HCFA to Medicare HMOs to assist in interpretation and compliance with HCFA regulations is presented in Table IV-2, below. In addition, HCFA issues Operational Policy Letters (OPLs) that clarify issues raised by Medicare HMOs about interpretation and operational guidelines for specific rules. (See Table IV-3). The Central Office forwards OPLs to HMOs that have requested information and clarification on the specific issue and also send them to the Regional Offices. Some Regional Offices send copies of the OPLs to all Medicare risk contractors in their Region, while others use them to provide direction to HMOs that contact the RO requesting clarification on specific issues.[4] In addition, some regional offices also issue letters or memoranda to clarify frequently raised issues. An overview of the information and material available to HMOs through the HCFA Web site, as of June 17, 1997, is contained in Appendix D of this report.

[4] The entire catalog of OPLs is now available to HMOs for downloading through HCFA's Web site.

Table IV-2: List of Written Materials Provided by HCFA to Medicare Risk Contractors

ENROLLMENT/DISENROLLMENT	PURPOSE
1. Transaction/Reply Report	1. Describes processing of plan record submissions and provides info on changes in enrollee's status (i.e., change in name or date of birth)
2. Special Status Report	2. Identifies beneficiaries receiving a special rate
3. Medicare FFS Bill Itemization Report	3. Notify plans when bills have been paid or processed on behalf of the Medicare members in the plan
4. Medicare FFS Bill Summary Report	4. Summary of bill processing and payments.
5. Beneficiary Adjustment Report (print image file plans download)	5. Specifies adjustment which affect monthly payments (including death and loss of Part B)
6. Demographic Report	6. Table of membership by demographic categories (array consistent with AAPCC rate book)
7. HCFA Plan Payment Report (printed; sent monthly)	7. Summarizes electronic payments sent to the plan's bank account for deposit during that month
8. Capitation Report (printed; sent monthly)	8. Displays total membership (current and one and two months prior) and enrollments recorded (for one, two, and three months ahead)
9. Semi-Annual Membership Listing (January and July; plans download)	9. List of plan's membership for both active and inactive members; Use for reconciliation of plan records with HCFA's (retroactive changes are not entertained)
10. Quarterly diskette	10. Medicare rates for services provided outside the plan's service area
11. Monthly Summary Report	11. Lists the monthly amount paid for each member
12. Plan Communications Guide	12. Explains NDM (direct electronics data interchange with HCFA), EFTS (preparing enrollment/disenrollment files), MCCOY (viewing enrollment/disenrollment info), GROUCH (to select GHP files or datasets from within GHP files), and PICS (ACR/BIF) systems; Technical details of data elements and format of records/reports on enrollment, disenrollment and status records; record format and files available for downloading after GHP monthly processing; technical details o how to electronically communicate with HCFA (sending records to HCFA, viewing records on the GHP system database and electronically receiving files from HCFA)
13. Medicare Enrollment and Payment Process User's Guide	13. Directions for plan records managers; describes responsibilities of HCFA and contractor, HCFA reports available to contractor, records submissions required of contractor and specific fields contained in each transaction

Table IV-2: List of Written Materials Provided by HCFA to Medicare Risk Contractors (Cont.)

14. Letters on Working Aged reporting (#31 refers to letters but does not relay any info included in letters)	14. Letter describing evolving working aged reporting which included list of carrier contacts
15. Letter on ESRD reporting (March 1996)	15. Guidelines and procedures for reporting and tracking of ESRD members
16. Schedule of submission of records to HCFA (latest in #31 and RO has available)	16. Schedule of MCCOY down days and deadlines or data reporting
17. Plan transfer tracking report	17. List of transmissions received (plan can see if on time)
18. Lock-in notice	18. Letter mailed to beneficiary immediately after they are enrolled in an HMO; reviews specific rules for provision of services
19. Retroactive Employer Group Report	19. Retroactive announcement of enrolled employer groups
20. MTS info pack	20. Explains MTS for managed care
21. Accepting the Year 2000 Challenge	21. Slides from systems seminar on data problems of reaching 2000 and how HCFA will handle systems conversion
22. Seminar-Medicare Managed Care Systems Seminar	22. Slides from OMC seminar on Enrollment and Payment Process (reporting, claims, who to call, responsibilities); Internet access; market penetration; reports list of statistical publications available for purchase; explanation of ESRD network functioning; CWF Advantis Network Access Manual
RECONSIDERATIONS AND APPEALS	**PURPOSE**
1. Reconsideration Notes	1. Quarterly publication for on-going plan education; forum for discussion of issues affecting the Medicare Reconsideration process and decisions; description of basic processes; difficult and frequently occurring cases
2. Annual Summary of Plans Appeals and Reconsideration Activity	2. National summary of decisions and value of contested claims; by category of service; by region; by plan
3. Appeal rights and procedures for beneficiaries enrolled in Prepaid Health Care Plans (Federal Register, Nov. 21, 1994)	3. Final rule modifies or established administrative review procedures for Medicare beneficiaries enrolled in HMOs
4. Program Information Memorandum - Immediate PRO Review of Decisions for Hospital Charges	4. Details and clarifications for implementation of final rule on appeal rights and procedures; covers notification, admissions, messages, notices of non-coverage, and clarifies requirements; list of documents that RO must approve format of before plan sends out; sample documents

Table IV-2: List of Written Materials Provided by HCFA to Medicare Risk Contractors (Cont.)

5. HMO/CMP/HCPP Appeals Process Questions and Answers	5. Defines internal grievances versus appeals; who can file an appeal; dealing with carrier claims for out of network services; definition of an organization determination; sample notice to enrollee; responsibilities of enrollee and plan
ANNUAL AAPCC/ACR PROCESS	**PURPOSE**
1. Plan Communications Guide	1. Describes how to use ACR functions of the PICS system to use ACR functions, manually enter ACR data and generate ACR reports; explains BIF functions of PICS including viewing summary benefit data and generating BIF reports; list of error messages, record layouts, troubleshooting techniques, sample reports
MARKETING MATERIALS	**PURPOSE**
1. National Marketing Materials Review Guidelines	1. Provide accurate and consumer friendly information; ensure uniform national interpretation of HCFA's review regulations and policies; conserve resources of plan and RO

Table IV-3: Index of OPLs Issued as of April 17, 1997

OPL95.001	Waiver of Beneficiary Co-payment
OPL95.002	Impact of 1994 Amendments of HCPPs
OPL95.003	1994 Amendments: HCPP Technical Issues
OPL95.004	Out of Area Conversion: Cost Enrollees
OPL95.005	Financial Responsibility for Emergency Services
OPL95.006	Subcontractor Compliance with Medicare Rules
OPL95.007	Signatures on Enrollment and Disenrollment Forms
OPL95.008	February 1995 Comparative Chart: Risk, Cost, & HCPPs
OPL95.009	Limiting Charge and HCPP Providers
OPL95.010	HCPP Compatibility with Medigap
OPL95.011	Administrative Review Rights for HCPP Enrollees
OPL95.012	Retroactive Payment Adjustments
OPL95.013	Retroactive Payment Adjustments (clarification)
OPL95.014	HMO Lockout of Providers
OPL95.015	Storage of Enrollment and Disenrollment Forms
OPL95.016	Military Treatment Facilities and VA Hospitals (MTF/VA)
OPL95.017	National Medicare Coverage of Lung Transplants
OPL95.018	Appeal Right for Premature Hospital Discharge
OPL95.019	Appeal Right for HCPP Enrollees
OPL95.020	Physicians, Providers & Suppliers Outside Service Area
OPL95.021	Impact of 1994 Amendments on Antiduplication Statute
OPL95.022	Non-Federally Qualified Line of Business
OPL95.023	Manual Manipulation of the Spine: Medicare Coverage
OPL95.024	Cost Reimbursement for Certain Services
OPL95.025	Plan Maintenance of Disenrollment Forms for Employer Groups
OPL95.026	Charge Structure Policy
OPL95.027	Employer Group Premium When a Flexible Benefit is Involved
OPL95.028	Administrative Fee Charged to Employer Group Retirees
OPL95.029	National Medical Coverage of Lung Transplants-Clarification
OPL95.030	Benefit Package Design and Charge Structures

Table IV-3: Index of OPLs Issued as of April 17, 1996 (Cont.)

OPL95.031	Calculating the 50/50 Rule
OPL95.032	Accretions into Health Care Prepayment Plans (HCPPs)
OPL96.033	Concurrent Risk AND Cost Contract Service Areas
OPL96.034	Conversion to Risk or Cost Contracts-Existing HCPP Enrollees
OPL96.035	Intermediate Sanctions
OPL96.036	Prompt Payment Requirement for Services or Supplies Provided by Non-Contracting Providers or Suppliers
OPL96.037	Point of Service Guidelines (POS) for Medicare Risk Contracting Plans
OPL96.038	Payments to Non-Contracting Medicare Participating Physicians by a Risk Contracting Organization
OPL96.039	Recoupment of Under-Payments by a Risk Contracting Organizations to a Non-Contracting Medicare provider
OPL96.040	Changes in Title XIII Regulations for FQHMOs: (1) the Employer Contribution to HMOs Regulation and (2) the Sunset of Dual Choice
OPL96.041	Telemedicine
OPL96.042	The Visitor Program-Affiliate Option
OPL96.043	Limits on Physicians' and Provider Charges for Out-of-Plan Services Provided to Members of Medicare Risk and Cost HMOs/CMPs
OPL96.044	Physicians' Advice and Counsel to Beneficiaries Enrolled in Medicare Managed Care Plans
OPL96.045	Changes in Physician Incentive Plan Regulations
OPL96.046	Managed Care Coverage
OPL96.047	New Reporting Requirements for Medicare Health Plans in 1997: HEDIS 3.0 Measures and the Medicare Beneficiary Satisfaction Survey
OPL96.048	Benefit Packages for Members of Associations, Including Recreation Clubs, Professional Societies, Chamber of Commerce
OPL97.049	Medicare Managed Care Plans' Benefits and Coverage of Certain Surgical Interventions for Treatment of Breast Cancer
OPL97.050	Open Access to Physicians' Panels
OPL97.051	Use of the Word "Medicare" in Marketing Managed Care Products to Medicare Beneficiaries
OPL97.052	FEHBP Members Enrollment in Medicare Risk Plans

V. INFORMATION NEEDS OF MEDICARE RISK CONTRACT HMOS

The Health Care Financing Administration provides substantial amounts of information to Medicare risk contractors during the application period. Once an HMO's risk contract is approved, considerable additional detailed operational information is provided and, on an ongoing basis, information on new regulations and requirements and clarifications of existing requirements are forwarded to the plans. In addition, during the application process, implementation, and ongoing operations, the HCFA Central Office and Regional Offices are in frequent contact with the HMOs to resolve problems and to provide clarification of requirements and interpretations.

This section of the report focuses on the information needs of Medicare risk contract HMOs, currently not being met by HCFA, that were identified through interviews with, and site visits to, risk contract HMOs, HCFA offices, PROs, and consulting firms that assist HMOs to apply for risk contracts. These additional information needs of HMOs differ somewhat among different types of HMOs and in different regions of the country. An HMO that is part of a national chain or that has been operating as a risk contract plan for many years may need less or different types of information from HCFA than an HMO that is an independent plan with no prior experience with Medicare risk contracts. However, there were many areas in which nearly all of the HMOs and other organizations interviewed agreed that additional information would facilitate more efficient operation of the Medicare plan.

Information Needed During the Application and Approval Process

HCFA currently provides the appropriate application form and supporting materials to HMOs that are applying for a Medicare risk contract. Additional information may be provided by Central Office and Regional Office staff, either verbally or in writing, when the HMO requests clarification or more information on specific topics. Most interviewed HMOs and some Regional Office staff indicated that the level of information and detail provided during the application process did not include sufficient detail to permit HMOs to move smoothly to implementation, once their application was approved. There was general agreement that providing additional detail and direction during the application process would be valuable to applicant HMOs, reduce the number of requests for clarification on specific issues, and facilitate HMOs' operational planning to implement a risk contract. Table V.1 summarizes the types of additional information that would be most useful during the application period.

Preparing the Application

Overwhelmingly, interviewees stated that potential applicants need to have clear and accessible information on all aspects of the risk contract program in order to apply for a risk contract and to operative effectively once a contract is awarded. The same information that is released by HCFA to operating Medicare risk plans should also be given to potential applicants; e.g., such information as the HMO/CMP Manual and updates, other manuals, Operational Policy Letters, Physician Incentive Plan regulations,

Health Plan Employer Data and Information Set, Version 3.0 (HEDIS 3.0), and the Consumer Assessment of Health Plans Study (CAHPS) requirements, National Marketing Guidelines and Standards for Review. These resources provide detailed, comprehensive information that would assist applicants to submit a responsive application to HCFA; often, applicants do not know of the availability of these resources unless they or their consultants have prior experience with risk contracting. However, to be the most useful, this information must be current and reflect current HCFA policies and regulations (refer to the discussion under "Information Process" below regarding the need for updated HCFA materials).

Table V.1: Additional Information That Would Be Most Useful During the Application Period

- Basic Information on Medicare and operational information on risk contracting, including:
  - ◊ HCFA Manuals;
  - ◊ Operational Policy Letters;
  - ◊ Transmittal Letters from Regional Office;
  - ◊ Guidelines/Regulations, such as National Marketing Guidelines, Physician Incentive Plan regulations, Standards for Review; and
  - ◊ Organizational structure of HCFA.
- Inform applicants of how long the application review process is currently taking and provide a contact person for the review.
- Inform applicants when there is a delay in the process, and the reason for the delay.
- Sources of information, including:
  - ◊ Published HCFA documents, with a brief description of contents, and instructions on how to obtain; and
  - ◊ HCFA contacts, by operational area, with e-mail addresses and telephone numbers.
- Information and data, including:
  - ◊ Medicare utilization statistics, by geographic area;
  - ◊ Information on studies conducted by, or supported by, HCFA on managed care quality, outcomes, utilization patterns, special population needs, and "best practices;"
  - ◊ Results of quality of care studies and outcomes surveys, by area of country and type of facility;
  - ◊ Quality measurement by hospital and skilled nursing facility (SNF), to assist in recruiting quality facilities for the provider networks;
  - ◊ Regulations affecting HMOs, hospitals, physicians, and other providers;
  - ◊ Listings of DRG-exempt facilities; and,
  - ◊ Physician fee schedules and DRG payment rates for hospitals.

In addition, it would be helpful to applicants, as well as to existing contractors, for HCFA to make available key sources of information. In particular, interviewees noted that a listing of published documents, with a brief description of the contents and instructions on how to obtain these materials, as well as a listing of HCFA contacts, by operational area, with e-mail addresses and telephone numbers would assist in the successful attainment of relevant and useful information.

The need for clear and accessible information is highlighted by the types of questions that some interviewed Regional Offices receive from inexperienced applicants that often do not understand the operational aspects of the Medicare program or the Social Security Administration (SSA) and, occasionally, from consulting firms representing an applicant. For example:

- What Medicare services do we have to provide to beneficiaries as a Medicare risk contractor?;
- What are the basic qualification requirements of potential entities that can apply to HCFA to become Medicare risk HMOs?;
- Where do we obtain utilization data required in the application?; and
- How do we interpret specific rules, such as the working aged, hospice, and the institutionalized?

RO interviewees noted that the completeness and accuracy of an application is, to some degree, a function of the applicant's knowledge of the Medicare risk program and the resources that the applicant can bring to the application.

Preparing for the Initial Site Visit

HMOs also indicated that it would be useful if HCFA would provide more information on the specific requirements and details that will be reviewed during the initial HCFA site visit. HCFA does send a letter identifying individuals HCFA expects to meet with and areas for discussion, but the information is perceived as being very vague. More detailed guidelines for the site visit would help plans to assure that the right people are available and the right materials are prepared in advance.

Other Information

In addition to receiving operational guidelines and requirements during the application process, interviewees identified a number of other areas where information would be useful during the application process. These include:

- Medicare utilization statistics in specific geographic areas, specifically comparative cost and utilization data available by type of service and region of the country--this would assist HMOs and physician groups in estimating the potential risk and financial prospects of Medicare risk contracting;

- Information on studies conducted by, or supported by, HCFA on managed care quality, outcomes, utilization patterns, special population needs, and "best practices;"
- Results of quality of care studies and outcomes surveys, by area of country and type of facility;
- Quality measurement by hospital and skilled nursing facility (SNF), to assist in recruiting quality facilities for the provider network;
- Regulations affecting HMOs, hospitals, physicians, and other providers;
- Listings of DRG-exempt facilities; and
- Physician fee schedules and DRG payment rates for hospitals.

HMOs would be assisted if these data and information were made easily accessible on the Internet or in hard copy.

Finally, interviewees indicated that it would be useful for HCFA to inform applicants of the real time involved in getting an application reviewed and approved, such as "At present, HCFA is taking **X** weeks from receipt of application to site visit review." During the application process, it would also be helpful if HCFA notified applicants when delays unrelated to the completeness of the application were occurring in the process, and the reason for the delay. It was felt that this information should be provided to applicants rather than the applicants having to seek it out actively.

Information Wanted to Operate the Medicare Risk Contract

Once the risk contract application is approved, HMOs move into implementation and ongoing operations of the Medicare plan. HCFA forwards a large volume of information and detailed guidelines for operation to the approved applicant, as has been described in Section IV above. However, risk contract HMOs and other interviewees identified several information needs that are not currently being met. Three categories of additional information needs were discussed and the findings for each category are summarized below:

- More detailed information on some aspects of operations;
- Information and data that HCFA or its contractors maintain but is only available if HMOs make an intensive effort to obtain it; and
- Information that is not currently provided by HCFA.

Table V.2 summarizes the information needs of on-going Medicare risk contractors.

Table V.2: Information Wanted/Needed by Medicare Risk Contractor HMOs

Upon Contract Award	
Operational Information	♦ Provide a basic package of materials (interviewees suggested that this occur during the application process), including: ◊ Information on the availability of MCCOY, CompuServe, and Litton ◊ All Reporting requirements and formats ◊ The HMO/CMP Manual and associated supplementary and clarifying materials ◊ Information on the HMO required contacts with the PRO, CHDR, local carriers/fiscal intermediaries ◊ A list of all relevant HMO publications that HMOs can obtain, if desired.
Operational Information	
Carrier/Intermediary	♦ Provide, for new enrollees, utilization data/prior claims history by type of service and diagnosis ♦ Provide clearer examples of what services/procedures are covered as determined by local carriers and fiscal intermediaries, especially for controversial medical areas ♦ Provide appropriate local prevailing physician Medicare fee schedules for determining reimbursement of out-of-area care
Accretion/Deletion Process	♦ Provide a monthly report reflecting an HMO's entire enrollee membership ♦ Provide a complete and accurate listing of codes used in reports, such as Reply Listings and Exception Detail; include accurate and current institutional status code on Special Reply ♦ Label cumulative 6-month report with start and end dates and disseminate the anticipated release schedule. ♦ Enable Litton/CompuServe to provide corrected information with the list of errors--presently, plans have to look-up although Litton/CompuServe have the information. ♦ Develop industry standards/methodology for calculation of voluntary disenrollment rates. ♦ Summarize changes made in manuals given to plans on an annual basis.
Marketing	♦ Inform plans on a regular basis where marketing materials are in the review process

Table V.2: Information Wanted/Needed by Medicare Risk Contractor HMOs (Cont.)

ACR Process	♦ Provide detailed information on the ACR review process, including delineation of rationale for steps and the detail behind each step ♦ Provide the methodology for how study factors are derived ♦ Provide a description of how AAPCC rates are developed and calculated ♦ Provide explicit instructions up-front on the information HMOs must submit, including the information requirements of reviewers. ♦ Provide explicit directions for how ACR information should be formatted (e.g., using LOTUS-DOS) ♦ Provide acceptable/unacceptable data sources and methodologies; ♦ Publish alternative "recommended" studies ♦ Provide guidelines for Medicare risk POS premium calculations ♦ Provide national demographic cost factors for utilization in the APR ♦ Inform plans on a regular basis where ACR submissions are in the review process.
Quality Improvement	♦ Release benchmark data (e.g., congestive heart failure and percentage of Medicare beneficiaries on ACE inhibitors) and access measures (e.g., sentinel events, such as inpatient admission that should not occur if quality ambulatory care is provided) ♦ Provide, under HEDIS 3.0, local area information, as well as overall industry information, to HMOs reporting information. ♦ Make the Standards for Review more explicit, such as types of QI studies a plan can perform ♦ Disseminate CHDR and BITS reports to all plans
Other	♦ Provide information on HCFA organizational structure and key contacts, by operational area, with e-mail addresses and telephone numbers ♦ Provide information on conferences where HCFA staff are scheduled to discuss specific issues ♦ Provide information on HCFA activities on an on-going basis ♦ Inform HMOs when HCFA staff will be out of the office, and identify a back-up person in his/her absence ♦ Provide guidelines for coordination of dual eligibles and how best to serve the special needs populations ♦ Disseminate to HMOs any information disseminated to other participants in Medicare risk program, e.g., hospitals, physicians, beneficiaries.

More Detailed Information

HMOs and other interviewees indicated that some of the information provided by HCFA did not address fully all of the operational issues that the HMOs needed.

Upon Contract Award

New contractors also noted the need to receive adequate written operational and regulatory information on the Medicare managed care program upon acceptance of their applications. For one plan, the only proactive information received from HCFA was a congratulations letter and a contract; this plan did not learn of the option to use either CompuServe/Litton or MCCOY until they had attended a HCFA seminar some time later. Another noted that its approval letter stated that it must meet specified reporting requirements, yet information on data and reporting requirements and the format in which they must be provided was not included. New plans also need advice at the on-set of a contract on certain set-up issues, such as expected interactions and contacts with Peer Review Organizations, the Center for Health Dispute Resolution (CHDR), and fiscal intermediaries/local carriers. Many new plans are uncertain as to whether they have a complete set of relevant HCFA publications and would like to have a complete listing of all materials on policy and operations available to them.

Accretion/Deletion Process

HMOs noted that the monthly enrollment/disenrollment report they currently receive is not cumulative, reflecting only individuals with changed status (such as, newly enrolled, disenrolled, died, changed addressed). Reconciliation becomes very difficult for HMOs when complete reports are provided only at six month intervals. For instance, HMOs have no way to reconcile the lump sum payment received against the members they are actually being paid for and whether they are being paid the correct amount on a monthly basis; and HMOs often have unresolved problems with enrollments because they are unaware of the problems until the twice-yearly reconciliation is received. In addition, some plans would like to have enrollment and disenrollment broken out by county.

While some plans were aware of HCFA's efforts to disseminate a "Monthly Membership Report," and were aware that part of the problem is that HCFA has a historical data system that was not designed to perform this function, they have been discouraged about the length of time it has taken to implement this change--as one plan indicated, HCFA had told plans it would be available starting in the Spring of 1996, then in December of 1996, and, as of the time of the site visits took place in January of 1997, it was unknown when plans would begin to receive this report. Subsequent to the site visits, HCFA has indicated that effective July 1, 1997, HMOs will receive a "Monthly Membership Report" that will indicate the monthly payment amount HCFA has given the HMO for each enrolled member. HMOs will continue to receive a monthly Reply Listing of changes in membership that the HMOs can use to maintain and update their records[5].

[5] Information was received from Ms. Marla Kilbourne, Acting Director, Data Development and Support Team, HCFA Office of Managed Care, in a telephone conversation on June 19, 1997.

A frequent comment made by plans about the six month cumulative report is that HCFA sometimes adds or deletes months without clearly indicating that this has been done. For example, a plan could receive a January 1 through June 30 report that also includes through July 31 or only goes through May 31. Consequently, plans spend a lot of time being frustrated that cases are not reconciling until they finally realize what HCFA has done. In addition, it would be helpful if HCFA provided the release schedule for the cumulative report.

Plans would also like to receive meaningful disenrollment information that could be used to assess their performance, and to answer such questions as:

- How many beneficiaries are going back to FFS, or other risk plans?
- How many beneficiaries are leaving within a short time and how many long-term members are leaving the Plan;
- Which disenrollments are due to mortality;
- What are the characteristics of new enrollees (transfer from FFS; other risk plans)?

However, based on current reports, high disenrollment means very little since HCFA can not remove individuals from the disenrollment data who move. As one interviewee noted, plans are "operating in the dark and would like to be able to make valid comparisons." To this end, it was suggested that HCFA take the lead in developing industry standards and a methodology so that a meaningful disenrollment report that could be distributed to all participating plans.

Some HMOs noted that they have, in the past, received CHDR's quarterly newsletter, Reconsideration Notes, although not recently. HMOs would like to receive this information in a timely manner as it assists them in understanding the expectations of CHDR and interacting with them.

Difficult to Obtain Information

Some HMOs indicated that information of some types is difficult to obtain, even though it may be available from HCFA (e.g., Medicare fee schedules from the local carriers). Not all HMOs have the capacity to seek out information effectively and, therefore, it would be useful for HCFA to ensure that HMOs are informed of the availability of all types of information and the mechanisms through which specific types of information can be obtained.

Local Carrier/Fiscal Intermediary

Interviewed plans indicated that they need to be able to access local carrier and fiscal intermediary data to conduct their Medicare business in an efficient manner. Regional carriers and intermediaries make local interpretations of coverage based on the local market--for instance, what is considered experimental in one state is covered in another.

Plans would benefit from clear examples of what they are responsible for covering and not covering, especially for experimental procedures and controversial medical areas such as lung reduction surgery or treatment of a solid tumor. Currently, this information is not readily shared with plans on a regular nor timely basis. Consequently, if a plan is following national Medicare coverage guidelines, it may miss pertinent coverage issues and, because it is unaware of these interpretations, may unintentionally deny care inappropriately.

Plans also need access to the appropriate local prevailing physician Medicare fee schedules from the local carriers and hospital DRG payment information from fiscal intermediaries for pricing medical care provided by out-of-area or non-network providers. Interviewed plans indicated that they often find themselves in an adversarial role in obtaining this information directly from the local carriers and fiscal intermediaries, as HCFA defers to the carriers and fiscal intermediaries and does not explicitly compensate them for answering questions and dealing with issues from the Medicare HMOs. Consequently, the carriers and fiscal intermediaries have no incentive to cooperate with, or to provide this information to, Medicare risk contractors. It was noted that not having access to this information can cause delays in processing a member's claim, as well as delays in reimbursing physicians and non-network hospitals who have rendered the care. HCFA mandates that plans send a letter to each member with a claim that is taking in excess of 50 days to process. Members often find the language of the letter upsetting and contact plans angry and confused.

Plans feel that HCFA should be more proactive in requiring carriers and fiscal intermediaries to report the appropriate fee-for-service information and policy interpretations to HCFA, as well as to the HMOs who serve Medicare beneficiaries. Interviewed ROs indicated that they provide information on carrier and intermediary contact people, but the names change frequently and it is difficult for HMOs to be certain that they are contacting the right people and to obtain answers in a timely manner. One RO has informed plans of the availability of carrier fee schedules on-line, and a diskette was provided from the one carrier that does not have a web page; the RO indicated that plans were "thrilled" to receive this information. As one plan noted, carrier bulletins that address individual policy issues can sometimes be accessed through the Internet, but a comprehensive set of policies, which would be the most helpful, is not available. Further, several ROs have extended invitations to the Medical Directors of Medicare risk plans to participate in regional Carrier Advisory Committees. This initiative is intended to create direct linkages between plans' Medical Directors and the local carriers to achieve a better understanding of local coverage policies.

Information Not Currently Provided

In addition, HMOs and other interviewees identified other information that would be useful, if it were provided by HCFA on a routine basis.

Local Carrier/Fiscal Intermediary

Several interviewed plans have instituted Health Risk Surveys/Assessments or constructed databases to fulfill the plan's need for beneficiary health information at the point of

enrollment. It would facilitate coordination and continuity of care to new enrollees if the HMOs received information on their new members' health status or prior utilization of services from carriers and fiscal intermediaries. In addition, receiving information on Medicare beneficiaries' prior claims history, such as inpatient utilization of mental health/substance abuse, upon enrollment would enable plans to monitor the lifetime limit. Currently, plans may not know that a new enrollee has exceeded the lifetime limit.

Accretion/Deletion Process

Some HMOs indicated that confidentiality clauses defined by HCFA with plans' third party administrators, Litton or CompuServe, prevent plans from receiving information on their own corrections. Currently, the third party administrator is able to send a list of data errors, but they cannot provide the corrected information. Because members, in their enrollment forms, have authorized plans to obtain information, plans are uncertain why this information cannot be shared.

HMOs have found HCFA's Enrollment and Payment Process and Communications Guide Manuals generally useful and well-written. However, because plans receive updated versions of these manuals once a year, it would be helpful if HCFA summarized changes made from the previous year; currently one would have to perform a side-by-side comparison to determine if changes have been made from one year to the next. In addition, HMOs would appreciate learning of any changes as they are made rather than on an annual basis.

Marketing

Some HMOs, on occasion, have become frustrated by vague comments received by RO staff on marketing materials and the unclear explanations provided when clarification of review comments has been seeked. For instance, submitted materials will be returned to a plan with the comments "rephrase," "reword," or "this not true, rephrase" next to entire paragraphs, without a clear indication of the direction or outcome that HCFA is seeking. While plans are not seeking the specific language to be used, they would appreciate clearer information on the problems with the marketing submission that would bring about closure in the approval process sooner.

Annual Filing/ACR Process Information

HCFA regulations present a broad outline of the ACR methodology, but are vague in terms of the exact methodology to be used in completing the ACR and in specifying acceptable sources of utilization data. While HMOs acknowledged that the annual seminar on the ACR conducted in 1996 provided useful information on the ACR process, some HMOs indicated that it would be helpful if HCFA provided:

- Detailed, yet clear and concise, information on the ACR review process, including delineation of the rationale for each step and the detail behind each step, including:
  - The methodology for how study factors are derived--if HMOs are to use the study factors, they must understand how to use them;

- ◊ How the AAPCC rates are developed, and, thus, calculated;

- Explicit instructions up-front on the information that HMOs must submit, including the information requirements of reviewers; and

- Explicit directions on how the ACR information should be formatted (e.g., using LOTUS-DOS) to ensure that HMO staff have adequate access to the software and staff knowledge of use;

Some HMOs also commented that it would be helpful for HCFA to publish and make available to HMOs earlier in the process, such as June:

- Clear guidelines that outline acceptable and unacceptable data sources and methodologies so that HMOs will not use inappropriate data, as well as guidelines for how Medicare risk POS premiums should be calculated;

- Alternative "recommended" studies in case HMOs have limited data or unavailable data to derive utilization factors; and

- National demographic cost factors for utilization in the APR.

Quality

Several interviewees noted that HCFA could assist HMOs by releasing national, benchmarking data. For example, HCFA could release congestive heart failure data and what percentage of Medicare beneficiaries are taking ACE inhibitors, and take the lead in developing access measures, for example, sentinel events, such as an inpatient admission that should not occur if quality ambulatory care is provided. It is perceived that HCFA has the ability to provide national statistics, as well as access to much useful information for benchmarking and quality improvement efforts.

Given that HMOs will be providing plan-specific information to HCFA under the HEDIS 3.0 reporting requirements, several HMOs commented that it would be useful for HCFA to provide, to each plan submitting HEDIS 3.0 information, local area information, as well as overall industry information. This information would enable plans to assess their individual performance against other local plans and the industry at large.

CHDR and BITS Reports

Plans believe it would be useful to receive the quarterly reports that the Center for Health Dispute Resolution (CHDR) produces, as well as HCFA's report on the number of beneficiaries accessing the Beneficiary Information Tracking System (BITS)[6] line. Receiving both of these reports would enable plans to do a better job. Several plans noted that currently only the Region IX office disseminates these reports on a routine basis to participating Medicare risk contractors. Plans noted that CHDR needs HCFA's permission to send the report and the HCFA CO, when requested, has declined to send the report to

[6] BITS is a case control system used by some, but not all, of the HCFA ROs to capture written and telephonic beneficiary inquiries related to managed care.

individual plans. Rather, the HCFA CO has informed plans that they can ask their respective ROs to send the report to them. One interviewed RO expressed concern about disseminating this information to plans as the report may unjustifiably "point fingers" at some plans--for example, a plan shown as having met the 60 day timeframe 50 percent of the time may have only had two cases.

Standards for Review

Specific comments plans made regarding HCFA's Standards of Review included:

- HCFA currently has items in its Standards of Review that are not addressed in the HCFA manuals; and
- HCFA could provide more detailed information on some areas of the Reviewer Guidelines, such as the types of quality improvement studies a plan can perform (focused studies, medical chart reviews/audits).

HCFA Structure and Activities

HMOs, as well as other interviewed groups, would also like to be better informed of HCFA activities and initiatives. This would not only assist HMOs in preparing for change, but would also provide HMOs with information that could be shared with their enrollees and participating providers in their network. Interviewees indicated that HCFA has numerous initiatives underway, and it would be helpful to receive information on their status. For instance:

- Several ROs and plans indicated that the Blue Shield of Minnesota was preparing a comprehensive database of all the local carrier and fiscal intermediary policies and fee schedules information that plans would be able to access either on-line or through the purchase of a software package; however, none of the entities knew of the current status of the project, leaving them to speculate whether or not the project has been completed, put on hold, or "faded/died away."
- Interviewees were aware of HCFA's current Reengineering Application and Monitoring (RAM) initiative, but were uncertain as to the operational changes that have resulted.
- HMOs have not heard of the results of an electronic enrollment pilot done a year ago.
- HMOs are currently seeking information and updates on the HCFA reorganization.

It would also assist HMOs if HCFA were to regularly provide information on the organizational structure of HCFA and key contacts within HCFA by operational and/or topical area, with e-mail addresses and telephone numbers. This would enable plans to communicate more effectively with appropriate HCFA staff. Some interviewees indicated that this information had been disseminated at AAHP conferences, and should be made more widely available. Some HMOs indicated the need to know when their key HCFA staff contacts are going to be out of the office, such as changing their voice mails to

indicate the length of their absence, and, just as critical, identifying an appropriate back-up person in their absence; for these plans, operations are sometimes put on hold until HCFA staff are available again. Plans would also like information on the conferences where HCFA staff are scheduled to speak and the specific issues that they will be addressing.

Other Information

Other information that HMOs would like to receive include:

- A list of sanctioned plans by topic of sanction, as this information could be used by other plans to increase compliance and to assist HMOs to avoid additional similar sanctions--if there are Freedom of Information Act constraints with the release of these data, HCFA should consider identifying topics without identifying actual HMOs by name;
- Guidelines for the coordination of dual eligibles and how best to serve special needs populations; and
- Any information disseminated to other participants in the Medicare risk program, including hospitals, fiscal intermediaries and carriers, physicians, and beneficiaries, e.g., receiving beneficiary communications would help HMOs to assist beneficiaries in understanding changes in the program and how best to access benefits.
- Answers to interpretative questions asked by other plans. HMOs understand that plan specific information must be kept confidential, but would like to have new or unique interpretations that could apply to all plans forwarded to them.

VI. INFORMATION PROCESS: ISSUES RELATED TO HOW INFORMATION IS CURRENTLY PROVIDED

Overview

HMOs and other interviewees identified key areas in which the communications between HCFA and participating HMOs could be improved, including:

- Updating and revising HCFA materials, particularly the HMO/CMP Manual;
- Improving the timeliness of information provided relative to HMO operational requirements;
- Improving the consistency between the HCFA CO, RO, and across ROs;
- Streamlining the information process and requirements; and,
- Coordinating information with HCFA contractors.

Table VI-1 summarizes the information process issues raised by the HMOs and other interviewees.

Updated and Revised HCFA Materials

Updated HMO/CMP Manual

Clear and accessible information on the operation of Medicare risk contracting is very important to the smooth functioning of the program for HCFA's beneficiaries, and for participating HMOs. Interviewed HMOs, Regional Offices, and consulting firms all noted that a revised, updated, and indexed HMO/CMP Manual would be a major benefit to the information process[7]. As almost every interviewed Medicare risk contractor mentioned, HCFA often cites the HMO/CMP Manual as the major information source for several key operational areas. HMOs use the Manual for the details of how HMOs should operate their Medicare risk programs on a day-to-day basis. Currently, the HMO/CMP Manual is out-of-date, contains inaccurate information or unclear policy definitions, and is poorly organized. Of particular concern is that there have been changes in laws and regulations that have yet to be reflected in the Manual. As a result, basic information and requirements for Medicare risk contracting are not available in a complete, accurate, and easily accessible form for HMOs that are applying for contracts or that are operating Medicare HMOs.

[7] HCFA is in the process of updating the HMO/CMP Manual, Publication #75; it is anticipated that the HMO/CMP Manual will be fully updated by mid-1998. This information was received from Mr. Frank Szeflinski, Managed Care Operations Specialist in the Denver Regional Office, on April 25, 1997.

Table VI-1: Information Process Issues and Suggestions Raised By HMOs and Other Interviewees

Information Process Issue	Suggestion
Updated/Revised HCFA Materials	
	♦ Revised, updated, and indexed HMO/CMP Manual ♦ Revise applications to explicitly state requirements ♦ Establish clean copies of background materials; update as necessary; and tab
Improve Timeliness of Communications Relative to HMO Operational Requirements	
Accretion/Deletion Issues	♦ Improve timeliness and accuracy of information/data exchange between SSA, HCFA, and HCFA's authorized vendors ♦ Improve timeliness, accuracy, and exchange of data used to determine specific categories of beneficiaries ♦ Review Reply Listing and Exception Detail codes for accuracy, currency, and completeness prior to disseminating ♦ Change timing of Reply Listing to be one week sooner ♦ Disseminate DRG tape in a timely manner ♦ Communicate changes affecting Medicare claims process in a timely fashion; summarize changes in one place
Payment Issues	♦ Inform HMOs as soon as an overpayment or underpayment is discovered or suspected
Dissemination of OPLs	♦ Disseminate OPLs as HCFA CO releases them or as ROs receive them
Timeliness of Communications and Responses	♦ Allow sufficient time for HMOs to implement changes in operational procedures and information systems when issuing policies, regulations, and/or guidelines ♦ Strive to have structure in place prior to implementation of policies, regulations, and/or guidelines ♦ Provide information to HMOs, at regular intervals, as HCFA's approach is being developed ♦ Move the Annual Renewal Process to be earlier in the year
HMOs' Ability to Reach HCFA Staff	♦ Provide to HMOs a list of CO staff who have specific responsibility for specific areas and issues ♦ Establish standards for timeliness of response ♦ Increase the number of HCFA staff or streamline communication process and information transmittal mechanisms to improve timeliness of response

Table VI-1: Information Process Issues and Suggestions Raised By HMOs and Other Interviewees

Periodical Reviews	♦ Allow sufficient time for HMOs to implement corrective action plan, to demonstrate change, prior to re-auditing
Consistency and Coordination Between the HCFA CO, ROs, and Across ROs	
	♦ Assign to HMO a specific HCFA CO contact person to coordinate all activities and to provide clarification to questions and problems ♦ Assign specific HCFA CO staff for specific topic areas to resolve inquiries and problems related to those topic areas ♦ Identify a 'point' person to answer questions about the status of the development of new, and updating existing, policies or regulations
Simplifying Information Processes and Requirements	
Designating HMO-specific and Corporate Medicare Liaisons	♦ Allow HMOs to designate an HMO-Specific and Corporate Liaison ♦ Carbon copy designated Medicare liaison on all HCFA communications
Streamline Application Process	♦ Streamline application process to be "less paperbound" and more a real-time activity ♦ Designate appropriate "boilerplate" sections of the application
Real-Time, On-Line Medicare Beneficiary/Eligibility	♦ Strive to make Medicare beneficiary eligibility a real-time, on-line activity ♦ Allow HMOs to maintain system logs for documentation
Streamline Marketing Approval Process	♦ Institute a national "use and file" policy
Coordination with HCFA Contractors	
	♦ Provide sufficient training prior to implementation of contractors/reviewers HCFA retains to perform HCFA functions, such as the ACR review, PRO review, and on-site quality monitoring. ♦ Improve communication between the HCFA CO, the PROs, and CHDR; clarify respective roles of HCFA, PROs, CHDR, and HMOs

Interviewees indicated that the HMO/CMP Manual would be improved by:

- Updating the contents of the Manual to reflect changes in regulations and policies, including incorporation of the relevant information covered in OPLs and, as appropriate, RO-specific transmittal letters/bulletins.
    - ◊ For example: the enrollment/disenrollment section is dated 1995, yet this feature of the Medicare risk program has undergone fundamental changes that make this information out-of-date; and, there is currently an inadequate discussion of employer-groups, which the Manual often refers to as "commercial," and the variety of benefit packages that can be offered.
- Making the language clearer as text often "jumps around" in terms of definitions.
    - ◊ For example: the language used in the provider contract/subcontract section is confusing and unclear, raising questions that range from "What constitutes a contract?" to "Who can sign a contract?"
- Consolidating text about program areas and coverage issues as HMOs currently have to pull information scattered throughout different sections, and across other manuals, to have a complete and accurate picture of requirements.
    - ◊ For example: the Manual currently does not outline comprehensively the circumstances under which drug treatments are or are not covered--a HMO, when writing its coverage policies, has to go through at least four Manuals (HMO/CMP, Carrier, Intermediary, Coverage Issues) to find all the relevant pieces.
- Including a table of contents and an annotated index by subject area, and;
- Adding clearer examples, such as sample letters for enrollment, billing, and denials, that contain the language that HCFA requires.

An updated and revised HMO/CMP Manual would also benefit newer HCFA staff who do not have detailed experience with the Medicare risk program.

Current problems with the structure and content of the manual make use of the CD-ROM version difficult. Benefits of having a CD-ROM are overridden by problems in finding the location of information.

Interviewees recommended that HCFA set up a system to update the Manual on a regular and timely basis. For instance, HCFA could consider implementing a schedule by which each functional area described in the HMO/CMP Manual would be updated. In doing so, it would be useful for HCFA to solicit the participation of HMOs for their feedback from the beginning of the process.

Other Printed Materials

Interviewed HMOs that had recently undergone the application process and consulting firms that assist clients in preparing applications acknowledged that HCFA provides

potential applicants with a substantial amount of information. However, these interviewees noted that the way in which HCFA presents information, and requests it, is perhaps more complex than it needs to be. Comments made about the vagueness of the current applications included:

- The application currently begins with a lot of detail and could be improved by incorporating an overview that provides a framework for the Medicare program; and,
- Requirements in the application should be explicitly stated and consistent throughout. For example:
  - ◊ What should be included in the health service delivery (HSD) tables--such as How should FTEs be expressed?; What types of providers (individual physicians, office sites, hospitals, or ambulatory care centers) should be included in each table?
  - ◊ How should maps be presented (overlays, clearly indicating counties) and should a specific software package be used to prepare them?
  - ◊ When should enrollment projections be submitted--should they be prepared for inclusion with the application and/or as of the time of the initial site visit (current language states both)?
  - ◊ What condition should contracts be in--should the application include approved and signed contractors or is draft form acceptable (current language states both)?
  - ◊ How should marketing materials be submitted--what are acceptable and unacceptable phrases to be used?
  - ◊ What software packages should be used to create the tables--does an applicant have to put tables into DOS files or can an applicant prepare its own tables using a different software package, such as PARADOX, using the tables in the application as a template?

Because of the ambiguity in the requirements and uncertainty about how HCFA interprets certain regulations, applicants tend to overdo it, providing as much information as possible, rather than risk submitting an incomplete or unresponsive application. HCFA, through it's Reengineering Application and Monitoring (RAM) initiative, may be addressing, or has addressed, some of the above comments.

The background materials distributed with the application are photocopied, and, subsequently, some of the materials are difficult to read. It is recommended that HCFA go back to the originals to reestablish clean copies. In addition, HCFA should tab the background materials by subject area rather than providing it as an eight inch stack of materials, the majority of which is relevant.

Timeliness of Information Relative to HMO Operational Requirements

Accretion/Deletion, Billing, and Payment Issues

HMOs currently rely on three key entities for timely and accurate information to enroll beneficiaries: the Social Security Administration (SSA), HCFA, and HCFA's two designated data contractors, Litton and CompuServe[8]. Many of the interviewed HMOs commented that they are affected by the timing of these key entities in updating their databases, as well as the accuracy of the data. Although HMOs are aware of HCFA's efforts to implement the Medicare Transaction System (MTS), this initiative is perceived as being "too far down the road" to be the answer to their immediate concerns.

The substantial lag times involved in updating databases and the accuracy of the data have a direct impact on Medicare beneficiaries, who often become caught in the middle of the back and forth dialogue between HMOs and HCFA. The following scenario exemplifies this:

1. SSA communicates Medicare beneficiary data (eligibility and demographics) to HCFA.
2. Upon receipt of these data, HCFA updates its databases and then the databases of its authorized third party administrators.
3. Because of the time lags in updating the databases, CompuServe/Litton may accept a member that HCFA in turn rejects, or vice-versa; for each rejected case, the HMO must request documentation ("proof") from the Medicare beneficiary.
4. Often, the member must subsequently communicate with SSA to correct the inaccurate information (not out-of-area; are eligible), which initiates the information cycle again.

This information cycle continues until HCFA's database, and those of Litton Computer Services and CompuServe, Inc., contain the correct information. This causes timely and unnecessary delays in getting Medicare beneficiaries enrolled, and causes unnecessary frustration and confusion for the member. Medicare beneficiaries may be left in limbo, and potentially with gaps in coverage, for several months while these events are transpiring. Further, HMOs would like HCFA to take the lead in performing reconsiderations that involve data which the SSA maintains.

HMOs also have problems with the timeliness and accuracy of data used to determine specific categories of beneficiaries, including the "working aged," ESRD, institutionalized, and railroad retirees. HMOs have had to devote significant resources to reconcile their

[8] Effective October 1, 1997, HMOs will be allowed to get beneficiary entitlement information through the Common Working File, not just through HCFA's contractors, CompuServe, Inc. or Litton Computer Services. HMOs will be permitted to view Part A and Part B entitlement, current hospice election, if any, and beneficiary ESRD status information. (Information provided through the HCFA Web site, June 17, 1997 and confirmed with Ms. Marla Kilbourne, Acting Director, Data Development and Support Team, HCFA Office of Managed Care, on June 19, 1997).

information with HCFA's by gathering data from members, as well as from relevant entities that may not feel an obligation to share the information with HMOs, sometimes within tight timeframes. For instance, HCFA requires HMOs to track down information that shows a member is ESRD, institutionalized, or that a member identified as "working aged" is, in fact, not working and not covered by an employer health plan. The use of the inaccurate data significantly impacts HMO payments, as well as causing potential problems for beneficiaries.

Other timing issues for information and communication related to accretion/deletion processes and payments include:

- Interviewed HMOs indicated that it is important that HCFA inform Medicare risk contractors, including formal notification of system-wide problems, as soon as HCFA discovers or suspects an overpayment or underpayment has occurred, as adjustments in payments affect HMOs' cash flows and their ability to manage capital effectively. HMOs indicated that receipt of the Payment Report, or a HMO's own reconciliation efforts, are often the first time that they learn of a HCFA payment adjustment.
- Several HMOs also noted that HCFA's Reply Listing often contains multiple reply codes that conflict and that the Exception Detail does not include an explanation of all of the codes that HCFA uses. Individual HMOs interviewed also mentioned situations that are resource-intensive to investigate and resolve, such as a group of members whose HIC number change each month; members inappropriately disenrolled because they are incorrectly shown as deceased; members never having their Part A effective date updated; and, members being disenrolled because they requested a change in their effective date. In addition, HMOs would like to see HCFA improving the Special Reply to ensure that institutional status is shown and is current for applicable members. Prior to disseminating these reports, HMOs requested that HCFA review the codes for accuracy, currency, and completeness.
- HMOs would like HCFA CO to change the timing of the Reply Listing to be approximately one week sooner; currently, the time between the receipt of the Reply Listing and HMOs' monthly enrollment/disenrollment submission to HCFA is a "crunch time."
- Several HMOs commented that they receive the updated quarterly DRGs on tape from HCFA. However, HMOs often do not receive this information in a timely manner. The length of time HMOs indicated it could take to receive the DRGs ranged from 45 to 60 days after the close of the quarter, to six months, and some HMOs stated they have never received the information.
- HMOs also indicated that while the HCFA Medicare Claims Processing Guidelines are clear cut, when HCFA makes changes in covered services or interpretation, this information is not communicated to Medicare risk contractors in a timely fashion. For instance, HMOs will receive updates #6 and #9, and six months later they will receive updates #7 and #8. When the filing the updates into the Manual, it is often difficult to determine what has changed without a side-by-side comparison.

Operational Policy Letters (OPLs)

Currently, HMOs commented that they may receive Operational Policy Letters (OPLs) from ROs in response to specific questions, or in batches after several OPLs have been released. HMOs believe it would be more useful to receive the OPLs as the HCFA Central Office issues them, or as the ROs receives them, rather than erratically. In general, HMOs would rather interpret HCFA regulations using complete information. It was noted that Regional Offices are inconsistent in their distribution of OPLs to participating HMOs and to applicants. One RO noted that HMOs "love" that it disseminates the OPLs as they are released, while another believes that dissemination is a HCFA CO function rather than an RO function. Subsequent to the site visits, HCFA has made the entire catalog of OPLs available for downloading through its Internet Web site.

Timing of Communications and Responses

HMOs were also concerned about the timeliness of HCFA communication, especially when the communication includes specific dates by which the HMO would be required to implement a particular change. Many of the HMOs interviewed stated that they believed that HCFA staff generally do not understand the operational issues and constraints faced by HMOs, and the time needed to implement changes in operational procedures and information systems. Examples most frequently cited by interviewees were: the implementation of the Physician Incentive Plan regulations, the implementation of HEDIS 3.0/CAHPS reporting requirements, and the current timing of the annual renewal process. Each is discussed below.

- *The Implementation of Physician Incentive Plan Regulations.* The corrected final regulations were published in the *Federal Register* on December 31, 1996, and were intended to be effective January 1, 1997. While HCFA had given guidance to HMOs through regional roll-out sessions, HMOs were concerned that roll-out sessions occurred too late in the process, and that final information (especially concerning implementation details) was not yet available. It is difficult for HMOs to provide HCFA with a description of how they intend to comply when they have a one day notice of what needs to be done to be compliant. HMOs commented that the regulations do not take into account their production processes or the amount of time involved in making changes. To comply, HMOs must devote resources to compile the necessary information and communicate with members and network providers, which cannot occur "overnight."
- *The Implementation of the Health Plan Employer Data and Information Set, Version 3.0 (HEDIS 3.0)/Consumer Assessment of Health Plans Study (CAHPS).* While HMOs applaud HCFA's effort to document the quality of care delivered and for working with such agencies as National Committee for Quality Assurance (NCQA) and Agency for Health Care Policy Research (AHCPR), some HMOs feel that HCFA is setting up time frames that will be extremely difficult, if not impossible, for them to meet. In September of 1996, HCFA informed established HMOs that they would have to report HEDIS 3.0 measures for all of 1996, leaving little time for some HMOs to implement programs or to have systems in place to collect the requested information.

As one interviewee commented, there is the perception that HCFA is creating "an unfair playing field" between those HMOs with the systems in place to collect the HEDIS information versus those HMOs currently without such systems--the short notice and the short time frames are what are making the playing field "unlevel." HMOs will have to make significant investments in the training of staff and refinements to, or implementation of, information systems. Because of the significant implications of reporting HEDIS 3.0 measures, HMOs would prefer that HCFA have a structure solidly in place prior to implementation so that they know exactly what to expect and can make the necessary program and systems changes. As one interviewee noted, having to make changes to information systems is like trying to "stop a train going 100 miles an hour."

HMOs also commented upon the length of time between communications, and the resulting implications. It has been disconcerting to HMOs not to have heard from HCFA until the end of December after the September 5, 1996 meeting, especially as there were changes between what was stated at the September meeting and what was released in December, such as reporting by MSA and whether HMOs conducting a NCQA survey also have to conduct the CAHPS survey. HMOs would find it useful and beneficial to receive information as HCFA is developing its approach, rather than infrequent bulletins.

- *The Annual Renewal Process.* Similarly, the annual renewal process is conducted on a time frame that creates difficulties for the HMOs and results in confusion and uncertainty on the part of Medicare enrollees in the HMOs. The timing of the release of the next year's AAPCC rates makes it difficult for most HMOs to submit their proposed ACRs' to HCFA before the November 15th required date. The review process of the ACRs takes several weeks to several months. (All ACRs submitted by November 15th are expected to be reviewed and approved by the end of December; however, significant delays have occurred on the most recent round.) Even if the HMO receives approval by mid-December, this timing makes it difficult to prepare materials describing any changes in benefits and premiums and send them to enrollees prior to January 1. Enrollees are anxious to know what changes in benefits and premiums have been made prior to the new benefit year and call the HMO with their concerns when the information is not made available. In addition, HMOs are put in the difficult position of not being able to change their marketing materials and begin charging different new premiums until sometime after HCFA has officially approved the benefits and premiums. It was suggested that HCFA move the AAPCC/ACR process to earlier in the year to avoid many of these problems.

Review of Marketing Materials

HMOs also find that the marketing materials review process often takes a lengthy period and involves multiple rounds with the Regional Office before approval is received. In particular, special initiatives tend to take longer as these projects are typically more complicated. Some reasons for delays cited by HMOs include: individual reviewer preference and style, as well as changes in policies that occur in the time between review

and resubmission. Since many of the HMOs are operating in highly competitive markets, these delays in approval may have adverse effects on their market position.

HMOs' Ability to Reach HCFA Staff

Other communication process issues raised by risk contract HMOs involve delays in being able to reach the Central Office or Regional Office staff when critical issues arise. When the RO plan manager is away on leave or on extended site visits, there sometimes is no back-up person who can provide information or make decisions. With the Central Office, HMOs often spend significant amounts of time trying to reach the appropriate Central Office staff person who can respond to inquiries or make decisions. It would be helpful if HCFA provided a list of CO staff who have responsibility for specific areas and issues, and establish standards for timeliness of response.

Several of the HMOs said that they understand that HCFA is understaffed, particularly given the recent rapid growth in the number of Medicare risk HMOs. However, if the program is to operate smoothly, it is important that communication and information dissemination occur on a timely basis. This may require either increasing the number of HCFA staff or streamlining the communication process and information transferal mechanisms to be improve timeliness of responses.

Periodical Reviews

HMOs indicated that HCFA must allow enough time to implement corrective action plans before returning to reaudit them. Because of the amount of time that elapses between the site visit, the written report of feedback, acceptance of a corrective action plan, and when HCFA returns, HMOs indicated that their corrective action plans have been in place a relatively short time. Even if HMOs worked hard to implement the needed corrective action, any sample pulled prior to the implementation date would show limited changes.

Consistency and Coordination Between the CO, RO, and Across ROs

A major issue raised by HMOs and others who were interviewed was the problem of consistency in the information that was received by the HMOs. Three specific areas were cited where inconsistency occurs:

- Different Central Office staff sometimes give different responses to inquiries about interpretation of rules and ways to resolve problems;
- Central Office and Regional Office staff sometimes give different responses to inquiries; and
- There are differences among the Regional Offices in their interpretation of rules and responses to inquiries.

The HMOs interviewed all said that they had positive relationships and open dialogue with the Regional Office staff, with whom they have the most interaction. However, inconsistencies in interpreting HCFA rules and guidelines between the CO and ROs and

among the ROs creates uncertainty and sometimes can put some HMOs at a competitive disadvantage with other Medicare HMOs.

HMOs speculated that one reason for the perceived inconsistencies could be that HCFA has hired or transferred a significant number of staff, with differing levels of experience with Medicare risk contracting, to provide support for the large number of new Medicare risk contract HMOs in recent years. Appropriate training for those new staff may not have been provided in sufficient detail, with the result that in some cases the HMOs find themselves in the position of providing education and information on HCFA's rules and procedures to new staff. The HMOs also indicated that inconsistencies may occur because HCFA manuals, guidelines, and other materials are unclear and no internal staff at HCFA has been devoted to developing a consistent interpretation and disseminating that interpretation to all HCFA staff at the CO and ROs.

Consistency in information provided and interpretations at the CO level of communication would be enhanced if every HMO was assigned a specific HCFA CO contact person for the coordination of all activities and seeking clarification to questions. This would, at a minimum, increase the likelihood of consistency for the HMO, since at present different CO contacts may interpret a specific issue differently. In addition, it would be helpful if specific CO staff were assigned responsibility for specific topic areas and were identified to staff within HCFA and to the HMOs as the person who could resolve inquiries and problems related to those topic areas. Regional Office staff would also benefit from this assignment of responsibilities at the CO, since they would know who to contact to obtain information and direction on specific topic areas. Similarly, when HCFA is developing new policies and updating regulations, it would be helpful to have a 'point' person identified at HCFA who could answer questions about the status of the policy or regulatory changes underway.

Interviewees suggested that many of the issues of inconsistency can only be resolved by the Central Office and that this may require significant effort on the part of the CO to review all HCFA materials as a group, develop a single interpretation for each rule or guideline, and then develop clear guidelines that could be disseminated to the Regional Offices. In addition, it would be helpful to involve RO staff in this interpretation of policies, rules, and guidelines and to discuss common issues that are raised and develop consistent approaches to addressing those issues.

HMOs also noted that HCFA's discussions with representatives of the industry are very valuable and should not be discarded. However, HMOs noted that a more appropriate time to solicit feedback would be after HCFA has identified an issue and before it drafts regulations. In soliciting comments from HMO representatives of the industry, consumers, and regulators, HCFA can learn if Medicare risk contractors can comply with aspects of the regulations and alternative methods that may be more appropriate.

HCFA has had the "lead Regional Office" system in place for marketing review for approximately three years. Both interviewed HMOs and Regional Offices noted that there

are problems with this policy that was intended to address inconsistencies in the approval of marketing materials for HMOs that operate in several regions. The RO designated as the lead is responsible for coordinating the review of marketing materials on behalf of the remaining ROs when a national chain has multiple Medicare risk contracts. Both participating HMOs and ROs have concerns with the current process.

HMOs are frustrated that, even though they have received approval of national marketing materials from a "lead" RO, individual ROs are requesting edits be made to the previously approved materials. Consequently, materials developed as part of a national campaign are no longer national but customized for each local market.

Interviewed ROs also indicated that the system is not always effective for several reasons, including:

- Even though there is more than one Regional Office involved in the review process, the amount of time to review the materials, 45 days from receipt, was not lengthened. As a result, the lead time for ROs to provide comments on the marketing materials to the "lead" Regional Office has shortened, which shortens the amount of time the "lead" RO has to synthesize and summarize comments.
- Materials written for other regions may not reflect differences in local markets.
- More experienced RO staff involved in the review process have greater expectations of a HMO. Consequently, RO staff do not feel compelled to accept the marketing materials that a "lead" Regional Office has approved for use across the country.

Simplifying Information Processes and Requirements

HMOs and other interviewees suggested a number of ways that information and communication processes could be improved and that reduce the burden on the HMOs and on HCFA staff. These include:

- Designating HMO-Specific and Corporate Liaisons
- Accepting "boiler-plate" portions of Applications/Area Expansions
- Having the verification of Medicare beneficiary information be an on-line, real-time process; and
- Institution of a "use and file" policy for marketing materials.

Designating HMO-Specific and Corporate Liaisons

Interviewed HMOs, as well as the convened Advisory Panel, noted that HCFA does not consistently know the appropriate contacts, or does not recognize the need to use specific contacts, at the Corporate level or at the local plan level[9]. Some HCFA communications are sent to the HMO President, others to the Chief Information Officer, and others to the

[9] HCFA indicates that the information on the appropriate contact person is provided by the HMO to HCFA for the mailing lists that are used to send information to the HMOs.

Director of Medicare Programs. The person receiving the HCFA communication is not always appropriate an may be unaware of the importance of an issue. This is of particular importance when HCFA is requesting a time-sensitive response from HMOs.

It is understood that HCFA and the HMOs have to be mutually responsible for information dissemination, with HMOs identifying the proper contact person who can assume responsibility for internal distribution. HCFA should also allow HMOs to designate both a corporate and a local HMO contact so that both sections of the company receive timely communications. By offering this choice, HCFA can accommodate the varied managerial structures among HMOs. In addition, HMOs would like their designated Medicare liaison to be carbon copied on all HCFA communications that other personnel within the HMO receive.

Multiple Applications and Service Area Expansions

Although the following is being addressed through the RAM initiative, HMOs with Corporate Offices that have submitted multiple applications, as well as service area expansions, reiterated that they would like to see the application process become "less paperbound" and be a more real-time process. Certain areas of the application, when an HMO has submitted more than one, become boilerplate and should not be included in future Corporate applications or service area expansions unless substantive changes have occurred. These areas include, but are not limited to, the systems and processes in place for claims; enrollment and disenrollment; information systems; quality improvement/quality management; utilization management; grievance and appeals; and, financial solvency.

Real-Time, On-Line Medicare Beneficiary Eligibility

Because of the substantial lags in verifying Medicare member eligibility, as discussed above, HMOs would like HCFA to strive to make Medicare beneficiary eligibility a real-time, on-line activity. HMOs noted that the current process, causes undue burden on HMOs and Medicare beneficiaries. HMOs believe that being able to perform real-time, on-line eligibility will improve the timeliness and accuracy of HCFA's data sources. Some HMOs commented that they would like to be able to maintain a systems log for documentation rather than having to retain paper copies in a file.

"Use and File" of Marketing Materials

HMOs noted that the marketing review process could be simplified by the institution of a national "use and file" policy based on an HMO's past experience of submitting "approvable" materials to the ROs. The "use and file" policy would reduce the length of time it takes to have marketing materials approved, would enhance HMOs ability to communicate efficiently and effectively with their members, and would allow HCFA RO to devote resources to other operational areas. The "use and file" approach is currently available to HMOs operating in Region IX, under which an HMO that has been in compliance and has shown an understanding of HCFA's marketing guidelines can begin to use some types of new marketing materials without advance approval. HMOs that have

the "use and file" option know that the privilege will be revoked if the privilege is abused by using inappropriate marketing materials.

Coordination with HCFA Contractors and Authorized Vendors

HCFA uses a number of contracted services to manage the Medicare risk contract program. HMOs and other interviewees indicated that HCFA may need to provide more training and give more specific guidance to these contractors to ensure that they perform effectively and are consistent with HCFA in their interpretation of HCFA rules and regulations. In addition, information and communication between the contractors, HCFA, and HMOs could be improved in a number of ways.

ACR Outside Contractor

HMOs noted that in 1996 HCFA retained an outside contractor to conduct all of the initial ACR reviews. The majority of HMOs interviewed found the 1996 ACR to be more challenging and duplicative than they had expected. A common comment made by HMOs was that this year there was a substantial amount of back and forth dialogue that occurred between them and the outside contractor, in part because the contractor was not sufficiently trained prior to beginning the process.

HMOs operating in more than one specific geographic area indicated they would like to see a more consistent review process across geographic areas and teams of reviewers, as they noted that there were some inconsistencies across geographic areas in the information that reviewers would request.

Peer Review Organizations

Peer Review Organizations (PROs) operate under a Memorandum of Agreement between HCFA and the PRO to monitor the care given to Medicare beneficiaries. Under the current Memorandum of Agreement, referred to the as the fifth scope of work, PROs are involved in quality improvement studies with HMOs, as well as the regular review of hospital notices of non-coverage and the receipt and investigation of beneficiary complaints related to HMOs.

HMOs are encouraged by the change in focus of PROs from random chart audits to focused quality improvement studies. Most HMOs indicated that they had developed good relationships with the PROs in their states, while others have had difficulty in establishing appropriate contacts. Several HMOs noted that some PROs, perhaps those with less experience, need education from HCFA on how HMOs work and the fundamentals of the quality improvement process. Several interviewed HMOs are participating in focused studies, either state-specific or under the leadership of HCFA. For focused studies involving HCFA, PROs act as the intermediary between HCFA and participating plans. HMOs participating in HCFA led focused studies commended HCFA and the PROs for soliciting their buy-in and for meeting regularly to discuss problems and to provide feedback on the program. While positive about their experiences, HMOs participating in

the HCFA and PRO focused studies noted several ways in which communication could be improved by HCFA, including:

- Devising a detailed strategy from the beginning, including the clinical indicators to monitor and the audit tools to be used;
- Improving communications about study designs, by clearing stating the operational changes or actions necessary on the part of participating HMOs; and
- Improving the timeliness of communications so that HMOs have adequate time to respond.

PROs indicated that HCFA communicates frequently regarding the focused studies. One area of improvement that PROs noted would be for HCFA to make an effort to coordinate its communication with the PROs--for instance, HCFA could issue a Monthly Update that presents in one place all the information relayed in various faxes and e-mails. HCFA should continue to communicate through faxes and e-mails, but because of the current volume of communications, important information may be lost within the text of the communication. In addition, HCFA could improve coordination by informing PROs of other quality initiatives HCFA is pursuing, such as the selection of a vendor for the validation of HEDIS 3.0 measures. It was also suggested that HCFA could improve communication and understanding by reissuing the study methodology once a number of significant changes have been made--currently, PROs must log all HCFA memos to understand study methodology, and HMOs that are working with the PROs tend to become confused when they receive the original study methodology followed by all of the changes. Finally, it was suggested that HCFA make an effort to provide comprehensive documentation to participating HMOs when distributing raw data collected through a focused study; this will become increasingly important as HCFA moves towards encounter-level data and validation.

Coordination Between CHDR, PROs, and HCFA. Some HMOs see a need for improved communication between the HCFA CO, the PROs, and CHDR, as currently there is confusion regarding the responsible entity for quality improvement oversight. HCFA should clarify each entity's respective role, such as CHDR has the final authority to resolve disputes and the PRO performs the final fact finding and investigation of suspected quality issues.

VII. HOW CAN INFORMATION BE EFFECTIVELY COMMUNICATED?

HCFA provides a large amount of information to Medicare risk contract HMOs, using a number of different communication methods. These include:

- Written materials,
- Verbal communication, by telephone and in-person,
- E-mail and electronic data transfers,
- HCFA Web Site,
- CD-ROMs, and
- Conferences and workshops.

HMOs and other interviewees were asked about communications strategies that would be most effective for HCFA to use to improve information flow and communication to improve the process and assist the HMOs and HCFA to work more smoothly and efficiently. While effective communication strategies may differ for HMOs with different characteristics and at differences levels of experience with risk contracting, all of the HMOs had suggestions for changes in communication strategies that they believed would improve the process. Table VII.1 summarizes the major recommendations made by those who were interviewed during this project.

The consensus among the HMOs and others that were interviewed is that HCFA is making good use of different types of communication strategies and that HMOs could obtain most information that is essential for effective operations of a risk contract HMO. The suggestions that were provided would expand the use of some types of communication strategies and make some types of information available in several different ways. Since HMOs have different levels of experience with risk contracting and vary in their technological expertise, offering information through multiple communication methods would increase the ability of all risk contract HMOs to obtain information and work effectively with HCFA.

Table VII.1: Summary of Major Recommendations Made by Those Interviewed During This Project

COMMUNICATION STRATEGY	SUGGESTIONS FOR EXPANDED USE/CHANGES
Written Materials	Written materials should be clear and complete; changes made to updated policies, regulations, and Manuals should be explicit--"this changed in relation to this particular regulation." Materials should be organized to ensure that all written materials on a specific topic are available in one place and/or are cross-referenced with other related materials. HCFA should designate one contact point for HMOs to identify and request all written materials that are available. This could be on the HCFA Web site, with a dedicated e-mail address for orders, or there could be an 800 number specifically for ordering written materials. HCFA should move towards providing timely written responses to outstanding inquires and issues currently answered verbally. Currently, HMOs find the need to maintain extensive documentation of verbal communications. The use of e-mail would facilitate this. HCFA should create and disseminate a newsletter which could provide timely and succinct information on HCFA activities, such as initiatives, demonstrations, and pilot programs, as well as the status of regulatory developments, that may offer plans opportunities to participate or may affect their operations. HMOs are presently not well informed of the status of various HCFA activities, and not all HMOs are members of AAHP or have access to outside counsel or government affairs programs in Washington, D.C. In addition, it is easy to lose track of the initiatives over time because of sporadic communications. It was indicated that most HMOs would be willing to pay to receive a HCFA newsletter that provided them with information and understanding of HCFA initiatives and regulations.
Verbal Communication, by Telephone and In-Person	HMOs would like one person assigned at the HCFA CO to serve as their contact person for the coordination of all activities and for seeking clarification to questions. HCFA staff should update their voice mail to indicate absences, and designate an appropriate back-up person with the authority to answer questions. HCFA could set up a telephone hotline that HMOs could access to receive clarification and consistent answers to specific regulatory or operational issues.

Table VII.1: Summary of Major Recommendations Made by Those Interviewed During This Project (Cont.)

COMMUNICATION STRATEGY	SUGGESTIONS FOR EXPANDED USE/CHANGES
	HCFA could develop a fax on demand service to provide up-to-date information on hot topics, as AHCPR and associations have done.
E-mail and Electronic Data Transfers	Many HMOs would prefer e-mail communication to verbal communications. E-mail communication would facilitate transmittal of questions and responses that are currently being handled by telephone and would produce written documentation of the issue discussed and direction given by HCFA. HMOs would like HCFA to strive to make beneficiary eligibility a real-time, on-line activity which would improve the timeliness and accuracy of HCFA's data and enable Medicare beneficiaries to be enrolled sooner. HMOs would like to be able to show a log for documentation rather than paper copies in a file. HCFA should move towards accepting the electronic file transfer of draft marketing materials--this would permit HCFA RO staff to make changes directly in the document, return to plans in a timely manner, and produce documentation of comments and approval. HMOs support HCFA's collection of ACRs on-line, noting this was a pilot project in 1996 that will be mandatory in 1997. However, not all plans received the relevant documentation or received it after their ACRs had been submitted. Those HMOs attempting the electronic submission were unsuccessful in doing so, because of the system freezing or designated passwords not working. HMOs feel strongly that HCFA, before making it mandatory, should test the system to ensure it works and disseminate the information in a timely manner. Implement a mechanism(s) for systematically tracking where various HMO materials are in the review process. HMOs would find it most useful to be able to track: ♦ Applications/Service Area Expansions, ♦ Review of Marketing Materials, and ♦ ACR filings. HMOs could be given a password for dial-in on-line access to the tracking system for access to plan-specific information. Modify the Grouch software to be more user-friendly, so HMOs can use the system more easily and the burden of training

Table VII.1: Summary of Major Recommendations Made by Those Interviewed During This Project (Cont.)

COMMUNICATION STRATEGY	SUGGESTIONS FOR EXPANDED USE/CHANGES
	new staff would be decreased. Enable HMOs to download the Exception List from the MCCOY system, HCFA's on-line database system that enables HMOs to view HCFA's master file of managed care enrollees. HCFA should require that all HMOs have the ability to accept WordPerfect 6.1 files, as WordPerfect 6.1 is HCFA's standard software package for word processing.
HCFA Web site	HMOs would like to see HCFA expand the amount of information available through the HCFA Web site, and develop a process for posting the information on a more routine and timely basis (reports posted within 1 to 2 weeks of release). Increased posting of materials on the HCFA Web site would reduce HCFA's burden in copying and mailing requested materials. Materials that HMOs would like HCFA to make available through the Web site are: ♦ OPLs--HMOs would prefer that the complete catalog of OPLs be made available on the Internet; at a minimum, HMOs would like a comprehensive index of available OPLs, by subject area; ♦ General information about HCFA, including conferences where HCFA staff will be speaking and a directory of HCFA staff, by responsibility for specific areas and issues, with telephone numbers and e-mail addresses; ♦ Routine HCFA reports; and ♦ Relevant statistics and data. Specific examples of reports and data cited include: ♦ Medicare/Medicaid Sanction reports, which some plans currently receive in hard copy once a year; ♦ CHDR and BITS reports, and analysis of disenrollment patterns; ♦ OSCAR-3 reports, which contain information that HMOs find helpful and an added value in credentialing SNFs for inclusion in provider network; ♦ List of participating providers; ♦ Local fee schedules and DRGs; and ♦ Messages sent through MCCOY, as data processors are not the appropriate staff to receive these. Some HMOs indicated that they would be willing to pay a fee to access reports on-line through a password system.
CD-ROMs	CD-ROMs of HCFA Manuals should be updated to be compatible with a Windows program rather than just DOS. HCFA should consider selecting a standard word processing program in which to publish reports and data; currently,

Table VII.1: Summary of Major Recommendations Made by Those Interviewed During This Project (Cont.)

COMMUNICATION STRATEGY	SUGGESTIONS FOR EXPANDED USE/CHANGES
	plans are dealing with unformatted, and sometimes unusable, ASCII files. OPLs should also be made available on a CD-ROM.
Conferences and Training	Given the emergence of new Medicare risk contractors and the use of consultants HCFA should offer several courses and seminars to current and potential risk contractors: ♦ A basic course on Medicare and the risk contracting program for inexperienced organizations that are considering applying for a contract; ♦ An Application Preparation seminar explaining the various sections of the application (such as, enrollment/ disenrollment, grievances and appeals, coverage issues, and marketing materials) and addressing frequently asked questions; this presentation would allow HCFA staff to more efficiently deliver information that they now repeat to many plans during various points of the application process; and, ♦ A course for new risk contractors discussing the operational and regulatory aspects of risk contracting. HCFA could make it mandatory that potential applicants attend a seminar series prior to being able to submit an application. HCFA staff that deal directly with Medicare risk contractors would benefit from a structured training program that would enable them to understand Medicare risk contracting rules and regulations and HMO operations, including monitoring of compliance. Structured training could include direct observation of plan operations to witness the sophistication of some operational aspects. HCFA may also want to consider having HCFA reviewers attend the NCQA "Building Blocks" sessions, as well as having at least one representative from each RO attending AAHP's annual Medicare/Medicaid conference that highlights industry-wide concerns. HCFA CO forums with plans and advocacy groups on new regulations or new interpretations of regulations, such as HEDIS/CAHPS, Enrollment and Payment, and Physician Incentive Plan regulations, are very helpful to HMOs. The seminars should offered in a timely manner to consider the operational impacts on HMOs. HMOs would like HCFA to continue offering such seminars, and, to the extent possible, expand their use. HMOs would like ROs to conduct meetings on a regular basis, such as quarterly, that bring together Medicare risk contractors to discuss issues affecting all HMOs and to conduct question and answer sessions. These sessions would allow RO staff to be aware of issues of concern to HMOs, as well as HMOs to be aware of the RO perspective.

VIII. DISCUSSION

The Medicare risk contracting program has been evolving over the past 12 years. After a number of years of slow growth in enrollments and declines in the number of HMOs participating in the program, the period since 1992 has been one of rapid increases in the number of risk contract HMOs and the number of Medicare beneficiaries enrolling in these plans. This has resulted in an significantly increased workload for HCFA staff responsible for reviewing and approving applications for risk contracts and for ongoing monitoring of operating risk HMOs. In 1992, there were only 83 HMOs in the program; over 150 new HMOs applied and began operating between 1993 and 1996. In the absence of some major change in federal policy affecting risk contracting, it is likely that there will be continued growth in the number of participating HMOs and enrollees over the next few years. Projections by CBO suggest that up to 25 percent of Medicare beneficiaries will be enrolled in risk contracts by 2002.

Managing information flows and designing effective communication strategies is a more complex task in a program that is rapidly changing and growing than it is when a program is stable in terms of participants and regulations and guidelines are well-established and change infrequently and only marginally. Hospitals and physicians participating in the Medicare fee-for-service program, for example, have had many years of experience and familiarity with HCFA requirements and regulations. While there have been major changes in the payment methodology over the past decade, these changes were phased in and involved extensive education campaigns. The Medicare risk contract program, on the other hand, has only been in existence for 12 years and requires much more comprehensive 'hands on' management and involvement of HCFA staff, as well as continuing refinement and development of requirements and guidelines that affect risk HMO operations.

Risk contract HMOs that were interviewed for this project generally stated that HCFA was very forthcoming with information that is necessary to operate the Medicare plan successfully. While they had specific suggestions about additional information that would improve the efficiency of the process and facilitate their operations, the greatest concerns raised were about information process. **Updating** materials to incorporate new regulations and clarify requirements was a suggestion that nearly all the HMOs made, as well as the consolidation of information which is available but spread among a number of documents issued by HCFA. Regular updating of manuals and other operating guides would ensure that HMOs had all the necessary information on any topic in one source. Similarly, **timeliness** of communication to enable Medicare HMOs to meet operational deadlines within timeframes required by HCFA was frequently raised as an issue. The HMOs also stressed that they sometimes have received **inconsistent responses** to inquiries about specific operational issues, and that it would be helpful to have HCFA develop a HCFA-wide process to ensure that all HCFA staff agree on the interpretation of specific rules and guidelines. **Additional training, direction, and oversight of HCFA subcontractors** who provide information and communicate with HMOs, to ensure consistency and facilitate effective operations, would also allow requirements to be fulfilled more easily

and reduce inefficiencies in the program. Finally, the HMOs were cognizant of the difficulties that HCFA staff may face in managing a program that is growing rapidly and made a number of suggestions that would simplify processes, reduce paperwork and interactions, and improve efficiency in the program.

Many of the HMOs' suggestions for effective communication strategies were centered around ways to improve information processes. For example, there is much information that could be placed on the HCFA Web site that, if available, would reduce the number of telephone calls between HMOs and HCFA staff or eliminate the need for HCFA staff to seek out information from other HCFA offices and subcontractors. Identifying a 'point' person in HCFA for specific issues would eliminate multiple telephone and written contacts with HCFA staff in order to obtain answers to specific questions. Finally, the suggestions for communication strategies reflect the fact that most of the interviewed HMOs have moved to use of electronic communication and have the ability to transfer data electronically. Developing a uniform consistent set of guidelines for using electronic communications and transfer of data would improve efficiency and reduce the burden on both HCFA and HMO staff involved in the Medicare risk contract program.

APPENDIX A

SUMMARY OF MANAGED CARE MODULE ADVISORY PANEL MEETING OF DECEMBER 12, 1996

HCFA On-Line: Market Research for Providers
Managed Care Module
First Advisory Panel Meeting
December 12, 1996; 9:00 a.m. - 3:30 p.m.

Meeting Participants By Organization:

Panel Members	HCFA	Barents/Westat
Pamela Bell	Sherry A. Terrell	Kathryn M. Langwell
Susan Rawlings	Steven B. Clauser	Maria Hewitt
Candace Schaller, Esq.	Richard Coyne	Lisa S. Rogers
Frank Szeflinski	John Meitl	Laura A. Esslinger
John T. Tighe, III	John Sirmon	Garret Moran
	Joyce G. Somsak	

The Managed Care Advisory Panel meeting began with an overview of the HCFA On-Line Initiative and a description of objectives of the "Market Research for Providers and Other Partners" project. The relationship between the "Market Research for Medicare Beneficiaries" project and this project was also discussed and it was noted that effective communication with providers and health maintenance organizations (HMOs) was an important aspect of improving information available to Medicare beneficiaries. Health Care Financing Administration (HCFA) representatives emphasized the importance of understanding the information needs of Medicare risk contractors and developing effective communication strategies that would meet those needs. The role of the Advisory Panel was discussed and the schedule of future activities for the project was laid out.

General Comments:

The Advisory Panel members had several general comments. First, the name of the project is confusing since managed care organizations do not think of themselves as providers. It would be less confusing to refer to this component of the project as "Market Research for Medicare Risk Contractors."

It was also noted that there are a wide range of managed care issues that are of concern to Medicare beneficiaries and that HCFA Regional Offices (ROs) and Social Security Administration (SSA) offices need to have information on managed care choices and policy to adequately address these issues, both for beneficiaries and for HMOs. In particular, complex issues faced by dual eligibles and by Medicare beneficiaries facing the need for long-term care services are as important to Medicare HMOs and to Medicare beneficiaries as are more operational issues such as general contracting, monitoring, and day-to-day responsibilities of Medicare HMOs.

Literature Review:

Barents staff presented an overview of the goals of the literature review and the methodology used to identify published sources of information on information needs and effective communication strategies for Medicare HMOs. Panel members offered suggestions and comments on the approach, including:

- No single source of literature is best and there are a large number of industry and trade publications--many of which may have incorrect information and/or may not be useful to review.
- It might be most useful to investigate seminars and conferences on Medicare risk contracting and to attempt to obtain copies of presentations (e.g. the American Association of Health Plans (AAHP) and the Blue Cross and Blue Shield Association (BC/BS)) that address issues related to HMO understanding of the Medicare risk contracting process, applications, and compliance issues.
- When HMOs are uncertain about a particular regulatory or compliance issue, the first place that they seek information from is the primary source; HCFA guidelines and laws (operational policy letters (OPLs) and regulations). Trade publications may prompt HMOs to seek out information on particular topics, but HMOs do not rely on such industry articles for details. HMOs often find out about new HCFA information sources through secondary sources of information.
- Large plans have an attorney who can decipher HCFA regulations and translate them into an understandable form. Plans also rely on lawyers who specialize in managed care and federal regulations in the DC area to get clarifications on interpretations of regulations.
- Associations, such as AAHP, spend a lot of time correcting erroneous information released in trade publications, investigating topics raised but not sufficiently addressed in the literature, and resolving problems created by misrepresentation of HCFA in industry publications. HMOs can access associations for support in interpreting HCFA policies and regulations correctly.

Interview and Site Visit Component:

Barents staff then described the telephone interview and site visit components of the project. The telephone interviews, to be carried out prior to the site visits, are intended to obtain preliminary insights and understanding of the information flows, information gaps, and communication methods that would be most helpful to Medicare HMOs. Results of these interviews will be used to develop site visit protocols and interview guides that focus on clarifying and elaborating these information and communication issues during in-depth site visits to Medicare HMOs in three cities. The Advisory Panel was asked to comment on the preliminary work plan for the site visits. Several points were raised by the Panel members:

- It is important that the interviews and site visits include discussions with both individual Medicare HMOs and with corporate offices that coordinate policy and processes for HMOs across the country. While the local Medicare HMOs are responsible for most of the day-to-day operations of the plan, the corporate offices develop coordinated policies and operational processes that are implemented by each plan.

- During site visits, it would be useful to begin with a general meeting of staff and managers of the HMO and raise general questions of information needs, communication processes, and ways that HCFA could improve information provided. This general meeting should then be followed up by individual meetings with operational managers who have ongoing interaction with HCFA around their Medicare product, including personnel who are responsible for:

  - Data communication
  - Claims
  - Quality (medical director)
  - Adjusted community rate (ACR) review / actuarial
  - Operational or plan direction (Medicare director)
  - Compliance
  - Enrollment
  - Legal counsel
  - Marketing
  - Development
  - Provider relations

- Generally, no two managed care companies have the same internal structure. The right individuals to meet with during the site visit to any HMO will depend on the size and experience of the plan. The general meeting at the beginning of each HMO site visit will provide an opportunity to ensure that the individual meetings will be with the right people and focused. It would be helpful to the HMOs to provide, in advance, an outline of topics and allow them to pull together the group of personnel. Plans are accustomed to selecting discussion groups, especially for RO visits.

- In a small plan, each individual does 15 different things. Project staff should be sensitive to time constraints where responsibilities are not spread out.

- It is also important in this project to explore the relationships between HCFA and contractors that it employs to review and conduct specific components of the Medicare HMO oversight process and the interactions between those contractors and Medicare HMOs. Adjusted Community Rate (ACR) contractors, for example, have communication problems with HCFA. HMOs send ACR submissions to HCFA and sometimes the ACR contractor reviewers do not receive all the information needed to complete the review.

- Medical Directors are the communication link between plans and carriers. Coverage decisions at the carrier level are relayed to HMOs through these directors. Proper communication regarding coverage decisions can not be accomplished directly due to

the competitive environment between carriers and managed care organizations. Carriers do not want to share information with HMOs. This is an issue that affects HMOs and makes it more difficult for them to ensure that they are making the right decisions on behalf of their Medicare members.

- ◊ HCFA/OMC has begun an initiative, announced in a memorandum from OMC to Medicare contracting cost and risk HMOs and state HMO associations, to invite HMOs to send a representative sample of their Medical Directors to Carrier Advisory Committee (CAC) clinical workshop meetings where Medicare coverage issues and policies are discussed and set.

- ♦ HMOs follow HCFA regulations regarding medical director communication which prohibit direct communications with carriers. It would be in the beneficiaries interest to establish channels and decide what data can be shared. Data on beneficiary health could be released once enrolled and would establish disease management immediately and facilitate continuity of treatment.

- ♦ Conducting interviews and site visits to a few HMOs that have exited the risk contract market could also provide useful insights and information for HCFA.

Focus Groups:

Westat staff then described the objectives of the focus group component of the project. Because HMOs in particular market areas may be very competitive and, therefore, might not be forthcoming about communication issues and information needs in a group that includes competitors, it was proposed by Westat that focus groups might be conducted at HMO conferences to draw on a population of HMOs from different geographic areas. The Advisory Panel provided the following suggestions:

- ♦ Panel members did not think that HMOs would be exceptionally reluctant to discuss the communication with HCFA in a group with other competitors, since the topic is not one that would be particularly sensitive or could give a competitor an 'edge'.

- ♦ Focus groups consisting of a number of Medicare risk contractors may be very useful in helping to identify uncover common problems and to develop some consensus on communication strategies that would be useful to HCFA.

- ♦ There are some drawbacks to conducting focus groups at national conferences. It is possible that HMOs that attend conferences may not be representative of all of the Medicare risk HMOs, so there could be some bias in the findings from the focus groups. It might also lose local flavor of markets and local operations by conducting focus groups at a national conference.

- ♦ Most participants would need to gather information in advance of the focus group from their plan's staff and operational managers or the discussion wouldn't be an informed one for all topics. It would be useful to send the questions and issues to be discussed to potential focus group members in advance so that they can prepare for the discussion.

- Suggestions for conferences at which focus groups might be scheduled:
  - ◊ BC/BS Association
  - ◊ Alliance for Healthy Aging
  - ◊ AAHP: policy conference in January
- Generally the non-profit conferences like AAHP or BC/BS will be much more flexible and cooperative than conferences sponsored by for-profit organizations. For-profit conferences will be more motivated if HCFA gets involved (letter from the Office of Managed Care (OMC)).
- Conferences tend to have a regional draw; if the focus groups are to be conducted at conferences then it would be best to schedule at one conference on the East coast and one on the West.

Provider Survey:

Barents and Westat staff then raised the issue of conducting a survey of HMOs to obtain additional insight and data on the information needs of Medicare HMOs and the best communication strategies for HCFA to develop. Because there are only about 700 HMOs in the country and less than half of these are Medicare risk contractors, the project team was uncertain whether it would be useful to conduct a survey or whether additional focus groups and site visits might be sufficient to obtain the necessary data. The Advisory Panel was unanimous in supporting a survey. They felt that it was essential for HCFA to obtain insight and information from a fully representative sample of HMOs and that a survey would be the only way to ensure that this occurred. Suggestions for the structure of the survey included:

- To obtain meaningful consistent data from HMOs on information needs and communication strategies, it will be important to identify the proper people to receive and respond to the survey in each HMO.
- When HMOs receive surveys they ask several questions to determine whether or not they will spend the time to respond:
  - ◊ Is the information requested proprietary in any way? If so, legal counsel's opinion will be sought.
  - ◊ If some or all of the information requested is proprietary, how the information is compiled and disseminated will be an important determinant of whether the HMO chooses to respond. If an individual HMO's responses could be released under a Freedom of Information Act request, that would be a deterrent.
  - ◊ Will the plan receive a copy of the product of the survey? If so, then the plan would be more likely to share information since they might benefit from receiving the final report showing the analysis and results of the survey.
  - ◊ Will all plans be answering questions from the some basis? In other words, does the survey clearly define what will be included in each answer?

- It could take up to two weeks for a plan to gather answers and submit the completed survey.
- Since this is a HCFA survey, intended to assist HCFA in improving communication and effective interactions with HMOs, the Panel believed that the response of HMOs would be very high.
- The Panel stated that, to be most useful to HCFA, the survey should be directed to all HMOs, including non-participating plans, risk HMOs, and cost contractors.

Communications Strategies:

The Advisory Panel was then asked to provide their own insights and experience on information needs and best communication strategies for HCFA and Medicare HMOs:

- The Panel uniformly stated that processes at HCFA could be improved by hiring additional support staff. HCFA Contract Officers have trouble keeping up with the huge workload and communications with HMOs are slow as a result. It takes too long to work through problems and to process requests. Generally, the application and approval process takes far too long.
- Information dissemination from HCFA to Medicare risk contractors does not necessarily follow systematic or proper channels. The HCFA database contains three contact names for each plan: the CEO, CFO, and a government relations/affairs liaison. When mailings are sent from HCFA to plans, they may go to one or all of these individuals. There is no systematic way of determining who is the best person to receive that particular information. A system needs to be set and followed so that plans will know who receives material and can organize internal information flows. A lot of time can be wasted in transferring information from corporate to local offices and vice versa.
- Panel members agreed that HCFA and the plan should be mutually responsible for information dissemination with the plan identifying the proper contact person who can assume responsibility for internal distribution. By offering this choice, HCFA can accommodate the varied managerial structure among plans. HCFA should also allow plans to designate both a corporate and local plan contact so that both sections of the company receive timely information.
- Monthly enrollment reports sent to HMOs are not cumulative (only reflect individuals with changes in status) and this makes reconciliation very difficult for plans when complete reports are provided at six month intervals.
  - ◊ HCFA is currently addressing this issue through a Data Development Support Team (DDST) that anticipates modifying the currently monthly reports to better meet the needs of the industry for cumulative enrollment data on a monthly basis. The DDST has industry participation.

- Communication with HCFA about the ACR review process is difficult because the outside contractor conducting the review does not have adequate knowledge of managed care risk assessment, terminology, etc.
- There are inconsistencies in the way HCFA enforces rules for submission of ACR data. Sometimes plans will submit data which is then rejected for not meeting requirements. Risk contractors then have to work with immense time pressure to correct problems which could have been resolved prior to submission if the plan had adequate knowledge of HCFA requirements.
- Plans need information on audits prior to the actual site visit. Auditing information and communication about the process can prevent discovery of new issues to resolve at the site visit. The three day visit is very intensive and it is unfortunate when plans think they are prepared, because they did not have adequate advance information on what is required, and do not learn of specific requirements until the site visit is underway. It is disheartening when problems delay an application when adequate information in advance from HCFA would have permitted the HMO to fully prepare.
- Many plans do use the HCFA home page and prefer on-line communication; however some smaller plans may not have Internet access or do not have staff who are knowledgeable of the Internet. If Internet communication became the primary source of much information provided by HCFA, then most or all plans would make Internet access and trained staff a priority.
- There are coordination difficulties and inconsistencies between HCFA Central Office and HCFA ROs on issues such as marketing and physician incentive regulations, and point of service (POS) applications. New guidelines and regulations are not sufficiently clarified for ROs who may interpret them differently than the Central office. Policies need to be specified more specifically and consistently across regions. OPLs are often not clear unless the person reading them is an attorney. Intentional vagueness of the law creates problems for implementation.
- ROs should not be implementing policies differently from the Central Office and from other ROs. It is unfair to plans to have a competitor receive approval for marketing materials in one region and then use those materials in a more strict region against other plans who had to meet the more strict guidelines.
- There are problems in designating a lead RO, a policy which was supposed to provide a way to address inconsistencies in approval of marketing materials for HMOs that operate in several regions. The lead RO should share information with the other ROs and gain their approval/comments. However, information is sometimes not shared or not shared in a timely manner. The lead RO should designate a comment period and coordinate the review. This way regionally appropriate materials can be developed through the simultaneous input of all ROs involved.
- HCFA has a current reengineering effort, Reengineering Application and Monitoring (RAM) to address problems with ongoing monitoring processes. It is expected that RAM will improve coordination between HCFA and states since a problem area has been with state regulators and monitoring at the RO level. The state regulators are

understaffed and fail to try to streamline the process of ongoing monitoring and oversight. Plans end up having to entertain several sets of auditors between the state regulators, accrediting organizations, and various components of HCFA oversight such as ACR and quality review. State regulations are often different from HCFA's and this creates a maze of inconsistencies for managed care organizations. However, states are generally happy to relinquish duties to HCFA with only a few exceptions where state regulations go above and beyond HCFA requirements (e.g. California). Sometimes the HMO can get caught in the middle trying to meet multiple sets of regulations.

  - ◊ HCFA has a current initiative underway called "Enhanced Review" which is an attempt to coordinate monitoring activities by NCQA, URAC, JCAHO, the states, and others. A workgroup within HCFA has also been established, the Single Set of Standards Workgroup (SSSW), to identify inconsistencies between federally qualified HMOs, and Medicare and Medicaid laws and regulations. It is anticipated that legislation will more than likely be necessary to bring all three types of HMOs, federally qualified, Medicare, and Medicaid, into regulatory consistency.

- Operational Policy Letters (OPLs) should be indexed and distributed as a complete set. All plans should receive new OPLs as soon as they are released. Right now plans only receive OPLs from ROs in response to specific questions. Plans want to have entire set of OPLs to refer to rather than finding out that one OPL raises issues also covered in another OPL which they don't have. Plans would rather interpret regulations using more information than be worried that interpretations have changed without their knowledge.

  - ◊ HCFA has recently made an effort to post all OPLs on the Internet, and ensuring that all current OPLs are disseminated to HMOs.

- HCFA forums with plans and advocacy groups on new regulations or new interpretations of regulations are very helpful. The forum on the Health Plan Employer Data and Information Set, Version 3.0 (HEDIS 3.0) and the Consumer Assessment of Health Plans Study (CAHPS) was very useful. The HMO Physician Incentive Regulation training/seminar (December 3, 1996) was also good in content, but offered too late in the process (AAHP paid for this event) to allow HMOs to meet the operational deadlines that were necessary. Similarly, HCFA day at the AAHP conference was excellent including the orange binder of HCFA materials that HMOs were given.

- Generally, HMOs find that Group Health Plan (GHP) on-line data system is better than CompuServe. There are some problems with set-up but once these are corrected, then the system works well. The Common Working File is still a problem because it is contained in a different database from GHP and there is no integration of information.

- With respect to information provided, the Panel indicated that it was important that HCFA should be operationally consistent and provide plans with one place to get information.

- Information distributed by HCFA needs to be clear and concise so that plans do not have to rely on other sources to translate information into a workable form. Secondary sources may make issues clearer, but they often offer incorrect interpretations.
- HMOs are not well-informed about HCFA initiatives, demonstrations, and pilots programs that may offer plans opportunities to participate or may affect their operations. The Advisory Panel suggested creating a HCFA newsletter which could provide timely and succinct information on HCFA activities while preventing the spread of erroneous information. HCFA ROs would also be interested in receiving such a newsletter. The Panel was certain that most HMOs would be willing to pay to receive a HCFA newsletter that provided them with information and understanding of HCFA initiatives and regulations.
- HCFA should distribute a list of sanctioned plans by topic of sanction. This information could be used by other plans to increase compliance and help HMOs avoid additional similar sanctions. Such information is critical to plans who want to do things "right." If there are Freedom of Information Act constraints with the release of these data, HCFA should consider identifying topics without identifying actual HMOs by name.
- Plans would like to have a seminar on the new organizational plan for HCFA. Now that OMC is gone they need to maintain their contacts and alter their communication patterns.
- Relational databases are needed. Plans rely on beneficiary claims to identify individuals with end stage renal disease (ESRD) and then notify HCFA. Fiscal intermediaries are slow making these corrections. HCFA is generally having trouble with databases and being able to link different sections of information together (ESRD with general Medicare managed care information, etc.). Right now a third party is responsible for identifying ESRD and they have no incentive to deliver. Meanwhile plans are paid at a lower rate; additional payments are automatically generated once determination made, and go back 3 years. Such adjustments are expensive to make. There is also an underreporting problem with nursing homes and in identifying working aged. Plans need beneficiary information in order to identify risk and receive the proper adjustments, as well as to better serve their vulnerable and chronically ill members.
- Nuts and bolts communication is very important to plans in order to make operational decisions. HCFA may lose plan participation when poor communication leads to ill-informed decision-making.

At the end of the Managed Care Advisory Panel Meeting, the Advisory Panel members said that HCFA should be commended for this effort to better understand the information needs of their beneficiaries, HMOs, and providers and for their interest in developing more effective communication strategies to improve the overall performance of the Medicare program.

APPENDIX B

APPROACH TO THE REVIEW OF THE LITERATURE

APPROACH TO THE REVIEW OF THE LITERATURE

A large number of information sources were screened as background to preparing the Managed Care Inventory and to guide the development of the Interview and Site Visit Protocols for this project. These information sources included:

- Data bases, including MEDLARS and LEXIS/NEXIS, were searched to identify literature and information sources on Medicare risk contracting, information, communication, and application processes. This search turned up a large quantity of citations; however, none of the citations reviewed were useful for identifying the information needs of Medicare risk HMOs or effective communication strategies.
- Newsletters and manuals directed toward Medicare HMOs were identified and reviewed to determine whether they contained useful insights and information of the information needs and communication processes that are relevant to HMOs interactions with HCFA. While a number of these contained useful "how to" information for HMOs entering or operating in the Medicare market, the focus was primarily on step-by-step operational compliance. No useful information for this project was found in these materials.

  Information and relevant literature was sought at the American Association for Health Plans library. Again, while much useful policy and operational information was identified at AAHP, none of the materials were directly relevant for this project.
- HCFA materials that are disseminated to Medicare HMOs were obtained and reviewed. This material provided the basis for understanding the information currently being provided by HCFA to HMOs and for developing a framework for the process through which HMOs are currently interacting with HCFA. This framework was then used to develop the Interview Guides and Site Visit Protocols that were used for the inventory and focus group components of the study.

Because no relevant information was identified in our search of the literature, no literature review was prepared for this project and included in this Inventory Report. Instead, the research team concentrated on reviewing HCFA materials in order to understand the current information flows and interactions and to assess current communication strategies. The results of this review are presented in Chapter III and formed the basis for developing the data collection strategy for the project.

APPENDIX C

SITE VISIT PLANNING AND CONDUCT AND DISCUSSION GUIDES

SITE VISIT PLANNING AND CONDUCT

Overview

This Appendix provides a comprehensive plan that describes the logistical activities to be undertaken in planning and conducting each site visit. The purpose of this plan is to structure the site visits in such a way as to minimize inconvenience to the interviewees or unproductive time on-site for the project staff. Although each element of this process is fairly simple, appropriate planning, with concern for detail, is very important to the successful outcome of the site visit.

The site visit plan involves a variety of interrelated tasks within the parameters of four basic categories:

- Site visit schedule
- Site visit planning and preparation
- Conduct of the site visits
- Post site visit activities

Each of these tasks is discussed in the remainder of this Appendix.

Site Visit Schedule

A schedule specifying site visit dates will be developed in order to give the interviewees advance notice and to efficiently plan the time of the site reviewers. At the present time, we anticipate that the site visits to three cities for the Managed Care Module will be conducted from mid-November through December of 1996. The site visits may be extended into January of 1997 if scheduling becomes problematic due to the Thanksgiving and Christmas holidays. Site visits for the Physician and Hospital Modules will probably be scheduled in the February through April 1997 period.

For each organization being visited, Barents will establish a primary contact for specifying the conduct of the site visits. At the time of contact with the designated primary contact, the general time frame of the site visit, with possible alternative dates within that general time frame, will be explored. Once the primary contact has agreed on a date for the site visit, site visit planning will begin.

Site Visit Planning and Preparation

The purpose of this activity is to complete arrangements for the site visits and to monitor the site visit process through the conclusion to see that there are no obstacles which delay the visits, or impede their success. The specific tasks included in the site visit planning and preparation are discussed below.

Identify Interviewees

After site visit dates have been agreed upon for each city, the Site Visit Coordinator will re-contact the primary contact from each organization to initiate interview plans. Prior to re-contacting each organization, materials containing a preliminary list of the types of individuals to be interviewed (i.e., Government Contracts, Medical Director, Information Systems) and the tentative timing of the site visit will be sent. Each organization will have the responsibility to identify appropriate individuals to be interviewed, based upon the types of individuals provided in the materials. Barents will obtain a brief job description for each identified individual. In addition, if applicable, the primary contact will make recommendations on groupings of individuals to be interviewed.

Interview Scheduling

After the list of all potential interviewee candidates is completed, the HCFA Project Officer will be consulted for any additional recommendations. Upon receipt of the final list of interviewees, the Site Visit Coordinator will send an informational letter to each individual designated by an organization prior to contact by telephone (to expedite matters, this letter will be faxed). This informational letter will contain an explanation of the project, the planned site visit dates, reference to the Project Director, the Site Visit Coordinator's name and phone number, and a planned time when the Site Visit Coordinator will call each designated individual to set up an interview time. The format of the informational letter will be submitted to the HCFA Project Officer for approval.

Approximately two to three days after sending the letter, the Site Visit Coordinator will call the candidates to make firm arrangements for participation. Standard language will be used to elicit participation. Letters confirming the telephone contact results will then be sent to all interviewees.

Travel Arrangements

Travel arrangements will be coordinated by the Site Visit Coordinator for the site visit team. The KPMG Travel Service Office will be used, as discounted rates are available. We anticipate two day site visits at each of the demonstration states, with the exception of three days for site visits to the West Coast.

Develop Work Materials for the Site Visit Team

A complete package for each site reviewer will be prepared by the Site Visit Coordinator. This package will include the following materials:

- Interview guides, containing questions and procedural steps, as appropriate, which will be used to structure and organize the information gathering process--the value of the highly structured interview guides is to ensure that the same information will be collected on each issue from similar respondents during each site visit;

- A personal agenda for each site reviewer specifying travel details (flight/train information, hotel accommodations, rental car arrangements), directions to the site, and the schedule of activities;
- An agenda for the interviews being conducted; and
- An agenda covering the timing of the post-visit report writing process and schedule.

Final Pre-Visit Check on Arrangements

One week before the site visit team is due to arrive on-site, the Site Visit Coordinator will initiate measures designed to make certain that no changes in circumstances have occurred during the weeks between last contact. The Site Visit Coordinator will call the designated contact person and each scheduled interviewee to determine if all arrangements are satisfactory. Any adjustments which are required (e.g., rescheduling certain interviews or substituting one interviewee for another) will be noted and the site visit team will be informed of these changes. In addition, all materials needed for the site visit will be checked for completeness.

Conduct of the Site Visit

As noted above, a substantial amount of effort will be associated with site visit preparation activities in order to make the site visits as productive as possible and the Interview Summaries as useful as possible. The actual conduct of each site visit will follow a general protocol. The following are the general guidelines that will be followed by the site visit team:

- The schedule must be adhered to;
- The interviewers should seek documentary evidence for all observations whenever available; and
- The site visit team will respect the privacy of the individuals interviewed and treat all documents according to the guidelines established by the participant who provided them.

Once on-site, the site visit team will carry out three major tasks:

- Initial Meeting with the Designated Contact. The purpose of this meeting will be to answer any questions regarding the nature and scope of the site visit interviews, to reiterate the project objectives and goals, and to obtain background information. In addition, these meetings will provide an opportunity for the site visit team to resolve any logistical concerns.
- Conduct Interviews. To the extent possible, depending on the availability of the participants, interviews will be conducted by all site team members. This will allow for greater probing on the part of the interviewers to uncover unique experiences and

characteristics of the organization, as well as to ensure completeness and accuracy with respect to the interview information obtained.

- Exit Interview with the Designated Contact. This interview will provide an opportunity for the site visit team to discuss the site visit process and experience with the designated contact. As such, these interviews will help to identify issues which may require follow-up contacts.

Post Site Visit Activities

Immediately following the site visits, draft Interview Summaries will be prepared and sent to key interviewees for review, augmentation, and correction. These summaries will serve as input to the Inventory Report.

Discussion Guide
Medicare Risk Contractors

Overall Project Objectives:

1. What information is needed by Medicare risk contractors from HCFA for effective participation in the Medicare risk program?; and,
2. How can that information most effectively be communicated and made available to Medicare risk contractors?

The goal of the site visit is to speak to appropriate representatives of Medicare risk contractors who are responsible for the day-to-day operations and communications with HCFA personnel in the following key functional areas: Compliance and Regulation/Legal Counsel; Data Submissions to HCFA (Enrollments/ Disenrollments and Claims); Finance (ACR review); Quality; Marketing; and Provider Communications.

Overall Assessment of Plan Communications with HCFA--Group Meeting

- Please provide a brief overview of the organizational structure of your plan.
- For each representative of a functional area, please state the top three to five current major problems you have in communicating with HCFA. Please identify any communication areas that HCFA currently performs particularly well.
- What information do you currently not receive from HCFA that you would find useful in fulfilling your Medicare risk contract obligations? that you currently receive?
- What communication strategies (such as electronic, CD-ROM, telephone hotline, newsletter) would be useful and accessible to your plan?
- Has your plan ever participated in an HCFA work group? What was your experience?

Application Process

Established Plans

- Have you recently expanded your service area in the local market? If yes, did you contact HCFA for clarification during the application process? If so, which components of the application required clarification and was HCFA responsive to your request?
- Do you have any suggestions for improving the application process?

Newly Established Plans

- Did you prepare the application internally or did you use an outside contractor? If you used an outside contractor, what factors led you to this decision?
- Did you contact HCFA for clarification during the application process? If yes, was HCFA responsive to your request? and which components of the application required clarification?
- Do you have any suggestions for improving the application process?

Compliance and Regulation/Legal Counsel

- Do the individuals identified by your plan as the Medicare Liaison receive HCFA communications? If not, who in your plan receives HCFA communications?
- What information does the Regional Office communicate to your plan? In what form is this information received (written materials that are mailed, faxed, or e-mailed; phone conversations)? Do you understand the content of the communications? Do you have any suggestions for how the Regional Office could improve communications?
- What information does the Central Office communicate to your plan? In what form is this information received? Do you understand the content of the communications? Do you have any suggestions for how the Central Office could improve communications?
- Should you need clarification regarding HCFA regulations, rules, policies, what process do you follow to seek clarification (internally, Regional Office, Central Office, trade industry associations)?
- Describe your plan's experience with HCFA's monitoring (site visit review) process. Are HCFA's communications regarding site visits (such as, scheduling, review criteria, feed-back) adequate? If not, what information is needed?
- Are HCFA's Manuals useful to your plan in remaining in compliance? If not, why? How could the Manuals be improved?
- What other sources of information does your plan use to stay informed about the Medicare risk program?

Data Submissions

- Do you use one of HCFA's contractors for the submission of enrollment/disenrollment data? Have there been any problems in communications? If so, what were they? and, what suggestions do you have to rectify these problems?
- How does HCFA communicate that a HCFA systems problem has occurred? Do you find this information adequate? If not, how could it be improved?

- Are HCFA's User's Guides for the Enrollment and Payment Process and Communications adequate for your health plan's information needs? If not, what should be changed?
- Are there any reports HCFA could share with plans that would improve operations?

Finance--the ACR Review Process

- Describe the experience your plan had during the most recent submission and review of its ACR filing.
- How does HCFA communicate to plans about the ACR process?
  Timeliness of information? Accuracy of information?
- What are your information needs regarding the ACR process?
- What other communication strategies could HCFA use regarding the ACR process?

Quality/Medical Coverage Decisions

- How has HCFA communicated to your plan quality initiatives? Is the information provided adequate? If not, why?
- What communications does HCFA have with your plan regarding grievances and reconsiderations? Are these communications adequate? If not, why?
- What types of communications does your plan have with the Peer Review Organization? Are these communications adequate? If not, why?
- How does HCFA communicate coverage information to your plan? Is the coverage information adequate? If not, why?

Marketing

- Has your plan been designated a lead Regional Office for the review and approval of marketing materials? If so, how has this experience been?
- Does HCFA review your marketing materials in a consistent manner? in a timely manner?

Provider Communications

- What types of information do you share with participating providers (physicians, hospitals, etc.) in your network regarding the Medicare risk program?
- How do you determine what information should be disseminated to participating providers? How do you solicit provider feedback on their information needs?

- What specific strategies do you use to provide the information to participating providers (such as, Provider Manual, newsletters, hotlines, educational seminars, brochures, computer access)?
- Are there strategies and/or innovations of which you are aware, but have not had the opportunity to utilize, for communicating to participating provides about the Medicare risk program?

DISCUSSION GUIDE
MARKET RESEARCH FOR MEDICARE RISK CONTRACTORS
Regional Offices

Overall Project Objectives:

1. What information is needed by Medicare risk contractors from HCFA for effective participation in the Medicare risk program?; and,
2. How can that information most effectively be communicated and made available to Medicare risk contractors?

Interactions with Medicare Risk Contractors

- What interactions does your office have with Medicare risk contractors? What has been your experience with each of these interactions (i.e., is there a difference between the types of questions asked regarding an initial application versus an expansion request?)

◊ Application; submission to award of contract
◊ On-site visits
◊ Marketing Materials (Type of Comments Given; Lead Regional Office)
◊ Provider Network
◊ Quality; Interactions with PRO
◊ Data Submissions (reconsiderations; ACR)
◊ Grievance and Appeals
◊ Fraud and Abuse
◊ Coverage Decisions

- For each interaction, what types of questions are Medicare risk contractors asking?

  Do you feel you have enough available information from Central HCFA to be able to answer the questions? If not, how to you respond to the question when additional information is needed? How to you gather additional information?

- What procedures do you use to address Medicare risk contractors problems and grievances? Are these procedures different from Central HCFA?

- What are the areas in which communication could be improved to assist HMOs meet the federal requirements of the Medicare risk contracting program?

Communication Strategies

- At this point, what are the most effective communication strategies used by your office or HCFA? What about the least effective? How is this effectiveness measured?

- What other organizations are you aware of that may be involved in communication efforts and/or innovations that would serve as useful models for HCFA On-Line? Is there active dialogue between your office and these organizations?

ASSOCIATIONS

Target Questions:

What are the information needs of your members regarding participation in HCFA's Medicare risk program?

- For your members, which information needs does HCFA best meet?
- For your members, which information needs are not currently adequately met by HCFA?
- What suggestions do your members have for HCFA to meet those needs?

Have your members suggested other communication strategies for receiving information from HCFA regarding the Medicare risk program?

- Which HCFA communication strategies do your members view as most effective?

Description of Department

Can you describe the overall function of your department? What are the specific responsibilities of your department? Are there other areas of your organization that communicate with HCFA?

Approximately, how Medicare risk contractors do you serve? Is there a typical person at the plan that you interact with on a continual basis?

Interactions with HCFA Regarding Medicare Risk Contracting

What do your members tell you are their major problems/obstacles interacting with HCFA regarding the Medicare risk program?

- Application
- Marketing Materials--seeking approval
- Provider Network
- Data Submissions
- Quality Monitoring
- Interaction with PRO
- On-site visits
- Coordination with Other Providers
- Fraud and Abuse

How do you assist your members in meeting these problems?

- Do you refer members to other organizations? If so, which organizations?

Do your members feel HCFA is responsive to their requests for information?

- If not, what are the problems?
- How do you members say HCFA could improve?

Do your members feel HCFA is accessible?

- If not, what are the problems?
- How do your members say HCFA could improve?

Communicating Information to Members on the Medicare Risk Program

What types of information are published by your organization about the Medicare risk program?

What specific means do you use to communicate information about the Medicare risk program to your members?

- Have you found these methods to be successful?
- How is their effectiveness measured?
- What specifically makes these strategies successful?

Sources of Information

- Are you aware of published literature or books that document the information needs of Medicare risk contractors?

APPENDIX D

OVERVIEW OF THE HCFA WEB SITE

OVERVIEW OF THE HCFA WEB SITE (as of June 17, 1997)

The Health Care and Financing Administration has developed and implemented a Web site, http://www.hcfa.gov/, available to any individual with access to the Internet. The following is a brief overview of information available through the HCFA Web site, as of June 17, 1997, that would be of considerable interest to health maintenance organizations and competitive medical plans[10] participating in the Medicare risk program.

The home page of HCFA's Web site includes "key" links to the following topics: Medicare; Medicaid; Publications and Forms; Local Information; Statistics and Data; Research and Demonstrations; Laws and Regulations; and Public Affairs. Items of interest to Medicare HMOs on the HCFA Web site include:

- A complete index of Operational Policy Letters (OPLs) that HCFA has issued, by letter number and date, as well as detailed instructions for how one can download the information
- Information on recent changes (regulations, policies, organization) of interest to HMOs, which are often highlighted by the word "NEW," such as:
  - Access to beneficiary entitlement information through the common working file effective October 1, 1997
  - Changes in the Service Area Expansion review process
  - Information on the Medicare Electronic Data Interchange (EDI), including formats supported (such as the UB-92); instructions for downloading the formats; telephone helpline numbers; and, HCFA 1500 and UB-92 instructions
  - Guidance from HCFA on the Physician Incentive Regulations
  - Information on the Medicare Integrity Program, as created through a provision in the Health Insurance Portability and Accountability Act, including a link to the Office of the Inspector General of the U.S. Department of Health and Human Services
  - The recent reorganization of HCFA ("HCFA Restructures to Serve Customers Better" in the June 1997 edition of *HCFA Health Watch*)
- Application forms and directions to apply for a Medicare contract as a Competitive Medical Plan; to apply for Federal Qualification (with or without requesting a Medicare contract); and to apply for a Medicare contract as a Federally Qualified HMO.

[10] In the context of this overview, the term Health Maintenance Organizations (HMOs) refers to both HMOs (federally qualified) and Competitive Medical Plans (not federally qualified).

- Reports, files, statistics, and datasets of interest to Medicare HMOs that can be downloaded, often with the appropriate HCFA contacts for technical questions and file contents, including:
  - Quarterly Market Penetration Reports, sorted by state and county or by state, county, and plan
  - Monthly Report and Summary Report of Medicare Managed Care Health Plans
  - Geographic Service Area Report for Risk and Cost Plans
  - Listing of Federally Qualified Managed Care Health Plans
  - HCFA statistics, such as persons covered by Medicare and national health expenditures for 1960 - 1995
  - Public Use Data Files, including, but not limited to: End Stage Renal Disease (ESRD) Renal Provider File; ESRD Facility Survey File; HCFA Hospital Wage Index Survey File; ICD-9-CM Version 14.0 File; Prospective Payment System (PPS) Payment Impact File; DRGs Relative Weight File; National Physician Fee Schedule Relative Value File; and, Clinical Diagnostic Lab Fee Schedule-National/Carrier File
  - Medicare Provider Analysis and Review (MEDPAR) files from 1990 through 1995
- Adjusted Average Per Capita Cost (AAPCC) and United States Per Capita Cost (USPCC)
- *HCFA Health Watch* newsletters

The HCFA Web site also includes linkages to other sites, such as the Government Printing Office; the Agency for Health Care Policy and Research; and the Office of the Inspector General, U.S. Department of Health and Human Services.